APPENDIX Q

GUIDELINES FOR DETERMINING IMMEDIATE JEOPARDY

PREAMBLE

Appendix Q - Guidelines for Determining Immediate Jeopardy

Changes made to Appendix Q, Guidelines for Determining Immediate Jeopardy, reflect HCFA's concern that crisis situations in which the health and safety of individuals are at risk, are accurately identified, thoroughly investigated and resolved as quickly as possible. In the interest of consistency, the new Guidelines standardize the definitions of Immediate Jeopardy, abuse and neglect across all certified Medicare/Medicaid entities (excluding CLIA), and describe the process surveyors use in making a determination of Immediate Jeopardy. The Guidelines provide a detailed analysis of the steps surveyors should follow to assist them in accurately identifying those circumstances which constitute Immediate Jeopardy: preparation, investigation, decision-making and implementation. "Triggers" alert surveyors that some circumstances may have the potential to be identified as Immediate Jeopardy situations and therefore require further investigation before any determination is made. A detailed review of three sample cases "walk" surveyors through the steps necessary to carefully analyze and accurately determine whether or not an Immediate Jeopardy situation exists. To provide further guidance to surveyors, Attachment B uses actual examples of situations in which Immediate Jeopardy has been cited.

In the interest of reducing or eliminating abuse and neglect to all beneficiaries, the Guidelines caution surveyors that when abuse or neglect has been identified, the circumstances must be thoroughly evaluated to determine if Immediate Jeopardy exists.

The Guidelines also clarify that actual harm, as well as the *potential* for harm, to one or to more than one individual may constitute Immediate Jeopardy.

Appendix Q

Guidelines for Determining Immediate Jeopardy

I. INTRODUCTION

Immediate Jeopardy is interpreted as a crisis situation in which the health and safety of individual(s) are at risk (see SOM §3010). These guidelines are for use in determining if circumstances pose an Immediate Jeopardy to an individual's health and safety. These guidelines will assist Federal and State Survey and Certification personnel and Complaint Investigators in recognizing situations that may cause or permit Immediate Jeopardy.

These guidelines apply to all certified Medicare/Medicaid entities (excluding CLIA) and to all types of surveys and investigations: certifications, recertifications, revisits, and complaint investigations. In these guidelines, "entity" applies to all Medicare/Medicaid certified providers, suppliers, and facilities. "Surveyor" represents both surveyors and complaint investigators. "Team" represents either a single surveyor or multiple surveyors. The term "Immediate Jeopardy" replaces the terms "Immediate and Serious Threat" and "Serious and Immediate Threat" for all certified Medicare/Medicaid entities.

NOTE: The primary goals of these Immediate Jeopardy guidelines are to identify and to prevent serious injury, harm, impairment, or death.

II. DEFINITIONS

The following definitions apply to all certified Medicare/Medicaid entities:

Immediate Jeopardy: "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR Part 489.3.)

Abuse: "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish." (See 42 CFR Part 488.301.)

Neglect: "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." (See 42 CFR Part 488.301.)

III. PRINCIPLES

The goal of the survey process is to ensure the provision of quality care to all individuals receiving care or services from a certified Medicare/Medicaid entity. The identification and removal of Immediate Jeopardy, either psychological or physical, are essential to prevent serious harm, injury, impairment, or death for individuals.

- Only **ONE INDIVIDUAL** needs to be at risk. Identification of Immediate Jeopardy for one individual will prevent risk to other individuals in similar situations.

- **Serious harm, injury, impairment, or death** does **NOT** have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.

- Individuals must not be subjected to abuse by **anyone** including, but not limited to, entity staff, consultants or volunteers, family members or visitors.

- Serious harm can result from both abuse and neglect.

- Psychological harm is as serious as physical harm.

- When a surveyor has established through investigation that an individual receiving care and services from the entity was harmed by a cognitively impaired individual due to the entity's failure to provide care and services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.

- Any time a team cites abuse or neglect, Immediate Jeopardy should be considered.

Upon recognizing a situation which may constitute Immediate Jeopardy, the investigation process must proceed until Immediate Jeopardy is confirmed or ruled out. The serious harm, injury, impairment or death may have occurred in the past, may be occurring at present, or may be likely to occur in the very near future as a result of the jeopardy situation. After determining that the harm meets the definition of Immediate Jeopardy, consider the following points regarding entity compliance:

- The entity either created a situation or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals.

- The entity had an opportunity to implement corrective or preventive measures.

After recognizing Immediate Jeopardy and completing the investigation, the team will then choose the specific Federal regulation(s) to address the deficient practice. Although a specific Federal regulation may not be found for each situation, all Medicare/Medicaid entities have a responsibility to provide quality care. The principles of Immediate Jeopardy apply to all certified entities and need to be followed for all individuals receiving care and services in those entities. The team should determine which Federal regulation(s) to document the deficient practices(s).

NOTE: The key factor in the use of Immediate Jeopardy termination authority is, as the name implies, limited to Immediate Jeopardy. Immediate Jeopardy procedures must not be used to enforce compliance quickly on more routine deficiencies.

IV. IMMEDIATE JEOPARDY TRIGGERS

This guide lists issues with associated triggers. The issues include general statements of practices such as "Failure to protect from abuse." The guide includes situations that most likely create jeopardy to an individual's psychological and/or physical health and safety.

Triggers that will assist the surveyor in considering Immediate Jeopardy accompany each issue. Triggers describe situations which will cause the surveyor to consider if further investigation is needed to determine the presence of Immediate Jeopardy. The listed triggers do not automatically equal Immediate Jeopardy. The team must investigate and use professional judgment to determine if the situation has caused or is likely to cause serious harm, injury, impairment or death. These triggers are general examples and are not all-inclusive. Many triggers may apply to more than one issue. A trigger for an issue such as C, "Failure to Protect from Psychological Harm," could well be an example of A, "Failure to Prevent Abuse," or B, "Failure to Prevent Neglect." The team must rely on professional judgment and utilize the resources of the State survey agency, the Regional Office and/or, in the case of Medicaid-only facilities, the State Medicaid Agency to determine the presence of Immediate Jeopardy.

NOTE: **Harm** does **NOT** have to occur before considering Immediate Jeopardy. Consider both potential and actual harm when reviewing the triggers in the table.

TRIGGERS

ISSUE	TRIGGERS
A. Failure to protect from abuse.	1. Serious injuries such as head trauma or fractures; 2. Non-consensual sexual interactions; e.g., sexual harassment, sexual coercion or sexual assault; 3. Unexplained serious injuries that have not been investigated; 4. Staff striking or roughly handling an individual; 5. Staff yelling, swearing, gesturing or calling an individual derogatory names; 6. Bruises around the breast or genital area; or 7. Suspicious injuries; e.g., black eyes, rope marks, cigarette burns, unexplained bruising.
B. Failure to prevent neglect.	1. Lack of timely assessment of individuals after injury; 2. Lack of supervision for individual with known special needs; 3. Failure to carry out doctor's orders; 4. Repeated occurrences such as falls which place the individual at risk of harm without intervention; 5. Access to chemical and physical hazards by individuals who are at risk; 6. Access to hot water of sufficient temperature to cause tissue injury; 7. Non-functioning call system without compensatory measures; 8. Unsupervised smoking by an individual with a known safety risk; 9. Lack of supervision of cognitively impaired individuals with known elopement risk; 10. Failure to adequately monitor individuals with known severe self-injurious behavior; 11. Failure to adequately monitor and intervene for serious medical/surgical conditions; 12. Use of chemical/physical restraints without adequate monitoring; 13. Lack of security to prevent abduction of infants; 14. Improper feeding/positioning of individual with known aspiration risk; or 15. Inadequate supervision to prevent physical altercations.

TRIGGERS

ISSUE	TRIGGERS
C. Failure to protect from psychological harm.	1. Application of chemical/physical restraints without clinical indications; 2. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals; or 3. Lack of intervention to prevent individuals from creating an environment of fear.
D. Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.	1. Administration of medication to an individual with a known history of allergic reaction to that medication; 2. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions; 3. Administration of contraindicated medications; 4. Pattern of repeated medication errors without intervention; 5. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction; or 6. Lack of timely and appropriate monitoring required for drug titration.
E. Failure to provide adequate nutrition and hydration to support and maintain health.	1. Food supply inadequate to meet the nutritional needs of the individual; 2. Failure to provide adequate nutrition and hydration resulting in malnutrition; e.g., severe weight loss, abnormal laboratory values; 3. Withholding nutrition and hydration without advance directive; or 4. Lack of potable water supply.
F. Failure to protect from widespread nosocomial infections; e.g., failure to practice standard precautions, failure to maintain sterile techniques during invasive procedures and/or failure to identify and treat nosocomial infections.	1. Pervasive improper handling of body fluids or substances from an individual with an infectious disease; 2. High number of infections or contagious diseases without appropriate reporting, intervention and care; 3. Pattern of ineffective infection control precautions; or 4. High number of nosocomial infections caused by cross contamination from staff and/or equipment/supplies.

TRIGGERS

ISSUE	TRIGGERS
G. Failure to correctly identify individuals.	1. Blood products given to wrong individual; 2. Surgical procedure/treatment performed on wrong individual or wrong body part; 3. Administration of medication or treatments to wrong individual; or 4. Discharge of an infant to the wrong individual.
H. Failure to safely administer blood products and safely monitor organ transplantation.	1. Wrong blood type transfused; 2. Improper storage of blood products; 3. High number of serious blood reactions; 4. Incorrect cross match and utilization of blood products or transplantation organs; or 5. Lack of monitoring for reactions during transfusions.
I. Failure to provide safety from fire, smoke and environment hazards and/or failure to educate staff in handling emergency situations.	1. Nonfunctioning or lack of emergency equipment and/or power source; 2. Smoking in high risk areas; 3. Incidents such as electrical shock, fires; 4. Ungrounded/unsafe electrical equipment; 5. Widespread lack of knowledge of emergency procedures by staff; 6. Widespread infestation by insects/rodents; 7. Lack of functioning ventilation, heating or cooling system placing individuals at risk; 8. Use of non-approved space heaters, such as kerosene, electrical, in resident or patient areas; 9. Improper handling/disposal of hazardous materials, chemicals and waste; 10. Locking exit doors in a manner that does not comply with NFPA 101; 11. Obstructed hallways and exits preventing egress; 12. Lack of maintenance of fire or life safety systems; or 13. Unsafe dietary practices resulting in high potential for food borne illnesses.
J. Failure to provide initial medical screening, stabilization of emergency medical conditions and safe transfer for individuals and women in active labor seeking emergency treatment (Emergency Medical Treatment and Active Labor Act).	1. Individuals turned away from ER without medical screening exam; 2. Women with contractions not medically screened for status of labor; 3. Absence of ER and OB medical screening records; 4. Failure to stabilize emergency medical condition; or 5. Failure to appropriately transfer an individual with an unstabilized emergency medical condition.

V. PROCEDURES

A. Preparation.--The team should be familiar with the contents of Appendix Q. The guidelines should be foremost in the team's mind to decrease the potential for missing Immediate Jeopardy. The team should also be familiar with the recommended Key Components of an entity's systemic approach to prevent abuse and neglect. The seven Key Components include: screening, training, prevention, identification, investigation, protection, and reporting/response. (Refer to Attachment C.) Both Appendix Q and the Key Components apply to all certified Medicare/Medicaid entities.

B. Investigation.--The investigation must be conducted in an impartial, objective manner to obtain accurate data sufficient to support a reasonable conclusion.

1. Observation is a key component of any investigation. All observations need to be thoroughly documented. Be specific in noting time, location and exact observations.

2. The interview notes must be clear and detailed. The documentation should include the full name of the person interviewed. The time and date of the interview should be documented. Any witnesses present should be indicated.

3. Record review is used to support observations and interviews. Obtain copies of relevant documentation supporting the Immediate Jeopardy as you investigate (e.g., nurses' notes, and investigation reports).

4. If the case involves a potential criminal action, the surveyor should be aware that any physical evidence must be preserved for law enforcement agencies.

5. Team Actions.--

a. Notify the team leader immediately when an Immediate Jeopardy situation is suspected. The team leader will then coordinate the investigative efforts.

b. Contact the State survey agency (SA) per the SA protocol.

c. Gather information to address who, what, when, where and why, such as:

WHO: Who was involved in the Immediate Jeopardy situation: staff, individuals receiving care and services, and others?

Does the individual(s) at risk have special needs? Has this happened to other individuals? If yes, how many? Are there others to whom this is likely to occur? If so, how many and who? Which entity staff knew or should have known about the situation?

WHAT: What harm has occurred, is occurring, or most likely will occur?

How serious is the potential/actual harm? How did the situation occur? What was the sequence of events? What attempts did the entity make to assess, plan, correct, and re-evaluate regarding the potential/actual harm? What did the entity do to prevent any further occurrences of the same nature?

WHEN: When did the situation first occur?

How long has the situation existed? Has a similar occurrence happened before? Has the entity had an opportunity to correct the situation? Did the entity thoroughly investigate the event? Did you agree with the facility's conclusion after their investigation? Did the entity implement corrective measures to prevent any further similar situations? Did they follow up and evaluate the effectiveness of their measures?

WHERE: Where did the potential/actual harm occur? Is this an isolated incident or an entity wide problem?

WHY: Why did the potential/actual harm occur?

Was the Immediate Jeopardy preventable? Is there a system in place to prevent further occurrences? Is this a repeat deficient practice? Is there a pattern of similar deficient practices?

The team then needs to proceed to **validate** the gathered information with facility staff.

Following are two examples of teams gathering information during the investigation to answer the questions: who, what, when, where and why. Refer to C. "DECISION-MAKING" for the completion of the examples.

EXAMPLE CASE #1: The resident was admitted following a hospitalization for psychiatric care. The resident had a history of exiting behavior, impulsiveness and impaired cognition and judgment. Diagnoses included dementia with psychosis and delusion, psychomotor agitation, acute behavioral disturbances, and possible right cerebral vascular accident (CVA). Documented behavior of standing by the facility door waiting for someone to open the door and then sneaking out very fast was included in the chart.

TRIGGER: Lack of supervision of cognitively impaired individuals with known elopement risk.

Investigation:

WHO: Who is the resident? Is the resident cognitively impaired with poor decision-making skills? Is the resident's diagnosis pertinent in this case? Is the resident physically impaired? What is the resident's ambulatory status? Was the resident identified by the facility as a wanderer oblivious to physical and safety needs? Does the resident have a history of leaving the facility without informing the staff? Does the resident's care plan address wandering and risk for elopement? Does the resident wear a safety alarm device? Is there a history of elopement from this facility? How many residents were/are at risk for elopement?

WHAT: What happened? What was the resident's physical, mental, and emotional status prior to elopement? Was the resident injured? Did the facility seek outside medical treatment for the resident? If so, what did the reports from the ER physician's exam include regarding the resident's condition when examined?

WHEN: When was the resident last seen? When did the resident leave the facility? When did the facility take action? When was the resident found? Who found the resident? Was the potential for injury present? Was the outdoor temperature excessively hot or cold? Was it raining, snowing, or storming, etc.? If excessively cold temperatures were present, what was the wind chill factor? How was the resident dressed? What areas of the skin were exposed and for how long?

WHERE: Where did the resident reside? Was the resident on a special unit with extra elopement precautions? Where did this happen? How did the resident exit the facility? Describe the exact location of exit. Where is the facility located (urban or rural)? What hazards were present in the vicinity of the facility (railroad, high motor vehicle traffic, construction zones, farm fields, lakes, ponds, etc.)?

WHY: Why did this happen? Was the care plan followed? Were door alarms working properly? Were exit doors visible at all times? If so, by whom? What was the facility's plan to supervise the resident? Was it followed? If so, why did it fail? What was the physician's version of the cause for harm? Were crucial medications involving therapeutic blood/serum levels involved in the elopement (i.e., insulin, psychotropic, antihypertensives, etc.)? What other contributing factors, such as diagnosis, should be considered?

EXAMPLE CASE #2: Confused, debilitated 75 year old female admitted as an inpatient to the hospital has orders to discontinue all nutrition and hydration support.

TRIGGER: Withholding nutrition and hydration without sufficient documentation of advance directives could be an Immediate Jeopardy situation.

Investigation:

WHO: Who wrote the order? Is this the patient's primary care physician? Who has the authority to make the medical care decisions? Does the patient have a living will? Does the patient have a durable power of attorney? Who has spoken with the person designated to make health care decisions for the patient; e.g., social worker, primary care physician, specialist, hospice nurse, or chaplain?

WHAT: What is the patient's diagnosis? Is documentation of a terminal disease process by the attending physician contained in the progress notes? What does the progress note contain about risks and benefits of discontinuation of hydration and nutrition? What alternative treatment options have been considered and discussed with the person responsible for making health care decisions for this patient? What events precipitated the decision to discontinue hydration and nutrition? What care and services have been planned during the absence of nutrition and hydration? What steps have been taken to ascertain the patient's wishes? What are the State laws regarding advance directives and end of life issues?

WHEN: When did the hospital obtain evidence of the patient's wishes regarding end of life treatment? When did the physician discuss end of life issues, diagnosis, prognosis and the patient's wishes with the person designated by the patient or by law to make health care decisions?

WHERE: If the patient has an advance directive, how easy/difficult is it to find in the chart to verify the patient's wishes? If the advance directive is not in the chart, does the chart indicate where the advance directive is kept? If the patient does not have an advance directive, where is the documentation in the chart to support the patient's wishes to discontinue nutrition and hydration at the end of life? Where is the documentation to support that the person making the health care decisions is fully informed of the risks and benefits and is making the decisions the patient would have made? If the patient does not have an advance directive, does the patient's chart reflect compliance with the State law and the legal representative's decision-making authority concerning withdrawal of hydration and nutrition? Has the person with decision-making authority been fully informed of all options, including home care, hospice and long term care placement?

WHY: If the physician wrote an order to discontinue nutrition and hydration, does the progress note contain documentation of the rationale? Is there clear documentation to support the decision?

C. Decision-Making.--The information gathered is used to evaluate the provision of related care and services, occurrence frequency, and the likelihood of repetition. The team needs to have gathered and validated sufficient information to address the three components of Immediate Jeopardy (listed below) to begin the decision process.

Components of Immediate Jeopardy.--

1. Harm.--

a. Actual.--Was there an outcome of harm? Does the harm meet the definition of Immediate Jeopardy, e.g., has the provider's noncompliance caused serious injury, harm, impairment, or death to an individual?

b. Potential.--Is there a likelihood of potential harm? Does the potential harm meet the definition of Immediate Jeopardy; e.g., is the provider's noncompliance likely to cause serious injury, harm, impairment, or death to an individual?

2. Immediacy.--Is the harm or potential harm likely to occur in the very near future to this individual or others in the entity, if immediate action is not taken? (Refer to the SOM 3010(B)(6) for timelines during normal termination.)

3. Culpability.--

a. Did the entity know about the situation? If so when did the entity first become aware?

b. Should the entity have known about the situation?

c. Did the entity thoroughly investigate the circumstances?

d. Did the entity implement corrective measures?

e. Has the entity re-evaluated the measures to ensure the situation was corrected?

NOTE: The team must consider the entity's response to any harm or potential harm that meets the definition of Immediate Jeopardy. The stated lack of knowledge by the entity about a particular situation does not excuse an entity from knowing and preventing Immediate Jeopardy. The team should use knowledge and experience to determine if the circumstances could have been predicted. The Immediate Jeopardy investigation should proceed until the team has gathered enough information to evaluate any prior indications or warnings regarding the jeopardy situation and the entity's response. The crisis situations in which an entity did not have any prior indications or warnings, and could not have predicted a potential serious harm, are very rare.

Team Actions.--

- Meet as a team;
- Follow Appendix Q;
- Share collected data;
- Identify the three components of Immediate Jeopardy;

-Decide if you have enough information to make a decision. If not, continue the investigation;

-Identify any inconsistencies or contradictions between interviews, observations and record reviews;

- Clarify any inconsistencies or contradictions;
- Determine the specific Federal regulation for the situation; and
- Consult with the SA, as necessary.

The following are examples of decision-making as the team analyzes the information obtained during the investigation. Example #1 and 2 are continuations from B-Investigation.

EXAMPLE CASE #1 (Continued): (Refer to B "Investigation") During the survey, the resident was observed to enter the code and exit the unit without assistance 5 times in 30 minutes and was brought back by nursing staff from the unit, nursing staff from other units and administrative staff. The front door to the facility had a broken alarm and did not latch properly and was easily accessible after exiting the locked unit. The facility was aware of the broken alarm and latch. The chart contained documentation that the facility was aware of the resident's ability to operate the door keypads for at least 60 days. The facility was located in an urban area on a busy street. A row of trees prevented anyone in the facility from viewing a resident exiting the property and crossing the street.

The record included documentation of the resident exiting the building successfully without notice. The documentation included only a brief description of the incident. After a search, the resident was located in an area emergency room being treated for a minor laceration of the lip. Police notified the facility that bystanders who had called 911 had found the resident lying down with blood on her face. The chart included subsequent reports of repeated frequent attempts to elope 25-40 times per shift, and the statement, "Patient requires 1:1, care not safe on this unit secondary to continuous exit seeking." A review of the facility investigations revealed that the facility had not completed any investigations for this resident.

Decision Making.--

- Has actual harm occurred? Yes.
- Does the actual harm that occurred meet the definition of Immediate Jeopardy? No.
- Is there a likelihood of potential serious harm? Yes.
- Does the potential harm meet the definition of Immediate Jeopardy? Yes.
- Is the harm likely to recur in the very near future, if immediate action is not taken? Yes.
- Did the facility have knowledge of the situation? Yes. If so when did they first become aware? Before admission when notified of history.
- Did they thoroughly investigate the circumstances? No.
- Did they implement corrective measures? No.

- Does this meet the definition of Immediate Jeopardy? Yes.
- Which is the most appropriate tag to define the failed practice?

Outcome.--

- The team identifies the most appropriate regulation that applies to the situation.
- The team proceeds with documentation of the Immediate Jeopardy deficient practice.
- The SA proceeds with the termination procedures per the SOM.
- Except in the case of Medicaid-only facilities, the RO proceeds with termination actions.

EXAMPLE CASE #2 (Continued): (Refer to B "Investigation") During the investigation, the surveyor finds that the chart does not include a copy of the patient's advance directive. The progress note does not contain any documentation of the patient ever stating a wish to have nutrition and hydration withdrawn at the end of life. The patient has a diagnosis of advance dementia with a documented history of refusal to eat in a long term care facility. The patient had been admitted because of continued weight loss and dehydration related to the refusal to eat or drink. The patient has a daughter who actively participates in her mother's care, is identified as the legal representative, and is identified in the social service notes as the closest living family member. The primary care physician documented a discussion with the daughter concerning the patient's poor prognosis for meaningful recovery. While death is not imminent as a result of the dementia, death is the expected result at some unknown time in the future. The chart does not include any documentation that the daughter expressed a wish to have nutrition and hydration support withdrawn. The social worker was unable to confirm that the daughter had expressed a wish to have all support withdrawn. The social worker is uncertain why the nutrition and hydration were discontinued. When contacted, the daughter is unaware that support has been withdrawn and is very upset. The surveyor copies the order sheet, the progress notes and the social service notes. The surveyor clearly documents the interviews with the social worker and the daughter. There is a discrepancy between the written order for withdrawal of support and the daughter's and the social worker's knowledge of the situation. The surveyor decides to present the information to the team prior to contacting the physician.

Decision Making.--

- Has actual harm occurred? No.
- Is there a likelihood of potential serious harm? Yes.
- Does the potential serious harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death? Yes.
- Is the potential serious harm likely to occur in the very near future, if immediate action is not taken? Yes.
- Did the facility have knowledge of the situation? Yes.
- If so, when did they first become aware? After the doctor's order was written?
- Did they thoroughly investigate the circumstances? No.
- Did they implement corrective measures? No.

- Does this meet the definition of Immediate Jeopardy? Yes.

- Which is the most appropriate tag to define the failed practice?

Outcome.--

- The team identifies the most appropriate regulation that applies to the situation.

- The team proceeds with documentation of the Immediate Jeopardy deficient practice.

- The SA proceeds with the termination procedures per the SOM.

- The RO proceeds with termination actions.

EXAMPLE CASE #3: An outside intruder entered a resident's room by cutting through the screen. A resident with a diagnosis of advanced dementia was raped. The resident did not notify staff at the time of the incident. The intruder was not observed entering the facility by any facility staff. However, nightshift staff immediately called the police after noticing a stranger in the courtyard at the back of the facility. The police came and were unable to locate anyone. The police checked the grounds without incident and then encouraged the staff to check the locks on the doors and windows and obtain services to monitor the premises for increased security. The police indicated that no prior intruders had been reported in the neighborhood.

The facility immediately contacted a local security service and hired a security guard to monitor the outside grounds. The security guard arrived within 45 minutes and began patrolling the grounds. The facility staff checked all the doors and windows to ensure security. They checked on all of the residents and did not observe any problems. During morning rounds, the resident reported that someone had hurt her during the night. The staff noted that the screen had been damaged and immediately contacted the police and the SA. The police came and had the resident transported to the nearest emergency room for a rape assessment. The emergency room confirmed that the resident had been raped.

Decision-Making.--

- Has actual harm occurred? Yes.

- Does the harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death to an individual? Yes.

- Is the harm likely to recur in the very near future, if immediate action is not taken? Yes.

- Did the entity have knowledge of the situation? Yes.

- If so when did they first become aware? In the morning when the resident reported she had been hurt.

- Did they thoroughly investigate the circumstances? Yes.

- Did they implement corrective measures? Yes.

- Does this meet the definition of Immediate Jeopardy? No. The facility reacted appropriately and followed the recommendations of the law enforcement experts to protect all residents. The harm to the resident had already occurred before the facility had any indications or warnings, and could not have been predicted or prevented.

Outcome.--

- The team gathered sufficient data to reach the conclusion that the facility had no predictable way of knowing that residents were at risk for harm from an intruder.

- The team also gathered sufficient data to reach a decision that the facility reacted immediately to protect residents when they had knowledge of a potential risk.

- The team concludes that there was no failed practice.

- The team concludes their investigation of this complaint.

VI. IMPLEMENTATION

A. Team Actions.--If the team reaches a consensus concerning the presence of Immediate Jeopardy, the team leader then contacts the SA per the protocol established by the SA. The SA review should be expedited. If the team is unable to follow the SA protocol for administrative consultation, actions to proceed with implementation of Immediate Jeopardy must continue. Decide if any other agencies need to be notified, e.g., Law Enforcement Agency, Nurses Aide Registration Board.

NOTE: Any criminal act needs to be reported to the local law enforcement agency. The entity should be encouraged to make the report, if needed. The surveyor should only assume this responsibility if the entity refuses.

B. SA Actions.--Upon review of the findings, if the SA concurs with the team's consensus of Immediate Jeopardy, the SA will inform the RO for all Medicare and dually certified entities. For Medicaid-only facilities, the SA will notify the State Medicaid Agency. For Immediate Jeopardy in Medicaid-only facilities, contact the RO per the protocol established between the SA and the RO.

C. Team Action.--Once the team has decided that Immediate Jeopardy exists, the team should notify the administration of the Immediate Jeopardy. A verbal notice should be given with the specific details, including the individuals at risk, before the survey team leaves the premises of the entity. The entity should begin immediate removal of the risk to individuals, and immediately implement corrective measures to prevent repeat Jeopardy situations. The team should encourage the entity to provide evidence of their implementation of corrective measures.

The notice describing the Immediate Jeopardy must be delivered to the entity no later than 2 days (refer to specific SOM reference) of the end of the survey. If official notification of all deficiencies, i.e., Form HCFA-2567, was not given on the second day, a completed Form HCFA-2567 must be sent to the entity on the tenth working day.

VII. DOCUMENTATION

A. Skilled Nursing Facilities/Nursing Facilities (SNF/NF).--

1. Confirmation of Removal of Immediate Jeopardy.--Only onsite confirmation of implementation of the facility's corrective actions justifies a determination that the Immediate Jeopardy has been removed.

2. Immediate Jeopardy Removed, Deficient Practice Corrected.--If the facility is able to remove the Immediate Jeopardy before the survey team leaves the facility and to correct associated deficient practices, cite the Immediate Jeopardy at the Immediate Jeopardy severity and scope (J, K or L). Document evidence of the facility's actions, including dates which indicate that the facility has removed the Immediate Jeopardy and corrected the deficient practice. The date of full correction will be shown on the Form HCFA-2567B.

3. Immediate Jeopardy Removed, Deficient Practice Present.--If the facility is able to employ immediate corrective measures which remove the Immediate Jeopardy, but an associated deficient practice still exists at a lesser severity and scope, cite the Immediate Jeopardy at the Immediate Jeopardy severity and scope. Include the documentation to support the remaining deficient practice. Document the level of harm and the identified residents in the Statement of Deficiencies. Attach the corrective measures submitted by the facility as an immediate plan of correction.

4. Immediate Jeopardy Not Removed.--If the facility is unable or unwilling to remove the Immediate Jeopardy before the end of the survey, inform the administration that the RO will be notified of the Immediate Jeopardy and termination procedures will be initiated. Use the appropriate SOM reference to define the end of the survey.

B. All Entities Not Noted Above.--Immediate Jeopardy is always cited at the **Condition** level on the Form HCFA-2567.

1. Confirmation of Removal of Immediate Jeopardy.--Only onsite confirmation of implementation of the facility's corrective action justifies a determination that the Immediate Jeopardy has been removed.

2. Immediate Jeopardy Removed, Deficient Practice Corrected.--If the entity is able to remove the Immediate Jeopardy and correct associated deficient practices before the team exits, cite the Immediate Jeopardy at the Condition level on the Form HCFA-2567. Corrective actions taken by the provider/supplier will be included in the Form HCFA-2567 documentation. The date of full correction will be shown on the Form HCFA-2567B.

3. Immediate Jeopardy Removed, Deficient Practice Present at Condition Level.--If the entity is able to employ immediate corrective measures which remove the Immediate Jeopardy, but an associated deficient practice still remains at the condition level for the same Condition of Participation, cite the Condition of Participation as not met and proceed with 90-day termination procedures. Include documentation of both the Immediate Jeopardy with subsequent removal, and the remaining deficient practice in this citation.

4. Immediate Jeopardy Removed, Deficient Practice Present at Standard or Elemental Level.--If the entity is able to employ immediate corrective measures, which remove the Immediate Jeopardy but an associated deficient practice still remains at the standard or elemental level, cite the Immediate Jeopardy at the Condition of Participation level on Form HCFA-2567. Cite the remaining deficiency at the most appropriate standard or elemental tag. The date of removal of the Immediate Jeopardy will be shown on the Form HCFA-2567B.

5. Immediate Jeopardy Not Removed.--If the entity is unable or unwilling to remove the Immediate Jeopardy before the team's exit, inform the administration that the RO will be notified of the Immediate Jeopardy situation and termination procedures will be initiated. In the case of a Medicaid-only facility, the State Medicaid Agency will be notified of the Immediate Jeopardy.

VIII. ENFORCEMENT

A. Termination for Title XIX-Only NFs, ICFs/MR.--Refer to SOM §3005 E for specific instructions.

B. Enforcement for SNF/NF.--Refer to SOM §§7307-7309 for specific instructions.

C. Termination for all other Medicare Entities.--Refer to SOM §3010.

IX. REFERENCES

SOM Appendices A-V (Excluding Appendix C, CLIA)

Principles of Documentation

SOM §3005E

SOM §§3010-3012

SOM §7307-7309

ATTACHMENT A

The jeopardy situations that follow are actual citations which have been upheld.

IMMEDIATE JEOPARDY NOT REMOVED BEFORE EXIT

ICF/MR Failed Practice

Condition of Participation.--The facility failed to assure medical services were provided to a client with an emergency medical condition.

Summary.-- At 4:30 a.m. on x/x/x, the nursing staff was notified that Client #1 had not slept during their shift and had three to four liquid stools that night. Nursing staff assessed the client, found his bed smeared with feces (color and consistency not described), his color slightly pale, abdomen slightly distended, and dried blood around his mouth. Assessed vital signs were blood pressure 100/60, heart rate 70 beats per minute, temperature 100.5 degrees Fahrenheit. His treatment consisted of Tylenol (given orally) at 5:10 a.m.

At approximately 5:45 a.m., Client #1 became unsteady while exiting the bathroom and was lowered to the floor with staff assistance. At 6:00 a.m., the client was described as,"skin cold, clammy - color pale." His blood pressure had dropped to 88/50, heart rate 85 beats per minute, oxygen saturation 93%. The client was placed on oxygen at 5 liters per minute and preparations were initiated to transfer the client to the infirmary.

At 6:25 a.m., Client #1 was still on the floor outside of the bathroom and the records indicated he was unresponsive. His blood pressure was 80/50, and his heart rate dropped to 67 beats per minute. The client tried to remove the nasal cannula that supplied him with oxygen and "insisted on sitting up." After sitting up, his skin was documented as decreased in color and "sallow." He had coffee ground drooling coming from both corners of his mouth.

At 6:40 a.m., the community emergency response number (911) was called. At 6:45 a.m., Client #1 was documented as being unresponsive with absent blood pressure, pulse, and respirations. Cardiopulmonary Resuscitation (CPR) was initiated. At 6:49 a.m., the community 911-response team arrived and took over CPR. The client expired at 7:00 a.m..

The Superintendent stated that staff were expected to use their own judgment as to when to access 911 emergency services. Review of facility Procedure #X revealed a lack of clear guidelines to facility staff on when to call for community 911 emergency response.

Issue.--Failure to protect from neglect.

Trigger.--Failure to adequately monitor and intervene for serious medical/surgical conditions.

Decision Making.--

- Has actual harm occurred? Yes

- Does the harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death to an individual? Yes

- Is the harm likely to recur in the very near future, if no immediate action is taken? Yes

- Did the entity have knowledge of the situation? Yes If so, when did the entity first become aware? On the night shift.

- Did they thoroughly investigate the circumstances? No

- Did they implement corrective measures? No

- Does this meet the definition of Immediate Jeopardy? Yes

- Which is the most appropriate tag to define the failed practice? Cite the most appropriate tag at the Condition of Participation level for Immediate Jeopardy.

Outcome.--The team cited the Condition of Participation, Health Care Services (Tag W318). The facility implemented a corrective action plan after receiving written notice. Onsite revisit confirmed correction.

IMMEDIATE JEOPARDY NOT REMOVED PRIOR TO EXIT

Home Health Agency Failed Practice

Condition of Participation.--The agency failed to assure medications were provided to patients in accordance with physician's orders and the patient's plans of care.

Summary.--Patient #1: The patient was admitted on x/x/x with a diagnosis of Insulin Dependent Diabetes Mellitus. Orders were: Humulin Insulin N 2 units and Regular (Reg) Insulin 3 units subcutaneously every morning and evening plus sliding scale Regular insulin coverage for blood sugar ranges of: 200-299=2 units Reg. Insulin, 300-399=4 units Reg. Insulin, 400+=6 units Reg. Insulin. The frequency of the sliding scale coverage was not included in the physician's orders, nor was the frequency of blood glucose testing. A subsequent physician's order for NPH 3u BID was transcribed as NPH 3 units every evening.

The Director of Professional Services made an assumption that the blood glucose testing and sliding scale insulin coverage was two times a day. Because of missing documentation, it was unclear when the patient actually received the correct dose of insulin. On 11 occasions, the patient's blood glucose levels were between 200-299 or 300-399. There was no documentation that the sliding scale was followed. On 6 occasions, the patient's blood glucose levels were below 200 and regular insulin was giving contrary to the sliding scale. On x/x/x, the patient's blood glucose was 431 and 4 units of regular insulin were given, rather than 6 units per the sliding scale.

Patient #2 - The patient had a diagnosis of Insulin Dependent Diabetes Mellitus and orders for routine insulin coverage BID. The plan of care included teaching the patient's caregiver diabetes management. There were no orders for blood glucose testing in the plan of care. The nurse directed the caregiver to perform blood glucose levels twice a day. Subsequent nursing notes indicated the caregiver was performing the blood glucose levels four times a day. On x/x/x, new orders for sliding scale insulin were received and implemented by the nurse without a frequency for administration. The nurse did not address the sliding scale insulin coverage or the caregiver's ability to carry out the insulin administration during subsequent visits. There was no documentation of the sliding scale insulin being administered to the patient.

Issue.--Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.

Trigger.--Pattern of repeated medication errors without intervention, lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction.

Issue.--Failure to prevent neglect

Trigger.--Failure to carry out doctor's orders

Decision Making.--

- Has actual harm occurred? No
- Is there a likelihood of potential serious harm? Yes
- Does the potential serious harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death to an individual? Yes
- Is the potential outcome likely to occur in the very near future, if no action is taken? Yes.
- Did the entity have knowledge of the situation? Yes
- If so, when did they first become aware? When an incomplete doctor's order was received.
- Did they thoroughly investigate the circumstances? No
- Did they implement corrective measures? No
- Does this meet the definition of Immediate Jeopardy? Yes
- Which is the most appropriate tag to define the failed practice? Cite the most appropriate tag at the Condition of Participation level for Immediate Jeopardy.

Outcome.--The State Agency attempted to hand deliver the completed HCFA-2567. The HHA was closed with a sign posted on the door indicating the agency was moving and the administrative staff was in the field making discharge plans for the patients. An on-call number was given. The on-call nurse stated that all of the agency's patients had been discharged. The agency submitted a written notice of closure upon request. State Agency completed a referral to the Board of Nursing regarding the Director of Nursing.

IMMEDIATE JEOPARDY REMOVED, DEFICIENT PRACTICE STILL REMAINS

SNF/NF Failed Practice

Severity.--Level 4, Scope - Isolated**--**The facility failed to prevent neglect, failed to provide appropriate emergency care, and failed to provide supervision to prevent accidents.

Summary.--The resident had a diagnosis of Alzheimer's dementia with a history of falls and wandering. The resident ambulated with a special walker. The resident was found lying at the base of a flight of stairs, in a pool of blood, bleeding from the nose and ears with a large laceration on his head. The alarm on the door leading to the stairs had not been reset after a fire alarm. Following

the resident's fall down the flight of stairs, the nurse talked to the resident, helped him to his walker and asked an aide to take him back to his room. The resident was not transported to his room, but was requested to ambulate using his walker with the stand-by assistance of an aide. The nurse returned to the unit, completed pending tasks and then called the doctor who directed her to call an ambulance. The resident was taken to the hospital and returned to the facility after a decision not to perform neurosurgery. The resident died 36 hours after the injury.

The resident fell while the nurse was off the unit in the boarding home giving medication. This was a regular part of the assigned duties for the nurse.

Issue.--Failure to prevent neglect.

Trigger.--Lack of timely assessment of individuals after injury and lack of supervision for individual with known special needs.

Decision-Making.--

- Has as actual harm occurred? Yes

- Does the harm meet the definition of Immediate Jeopardy, e.g., serious injury, harm, impairment, or death to an individual? Yes

- Is the harm likely to recur in the very near future to this individual or others in the entity, if immediate action is not taken? Yes

- Did the entity have knowledge of the situation? Yes. If so, when did they first become aware? Prior to the fall, when a history of falls and wandering was documented.

- Did they thoroughly investigate the circumstances? Yes

- Did they implement corrective measures? No

- Does this meet the definition of Immediate Jeopardy? Yes

- Which is the most appropriate tag to define the failed practice? Cite the Immediate Jeopardy at the appropriate tag. Also document the remaining deficient practice under the same tag. Define the level of harm for the residents in the failed practice statement (e.g., the facility failed to prevent neglect for 1 of 10 residents (#8) which resulted in Immediate Jeopardy, and for 2 of 10 residents (#4 and #5) which resulted in harm).

Outcome.--Revisit confirmed the removal of the Immediate Jeopardy; however, during revisit, another Immediate Jeopardy was recognized**.** A subsequent revisit confirmed the removal of the second Immediate Jeopardy identified. A deficient practice still remained. Termination stopped. Substantial compliance was reached 30 days later.

ATTACHMENT B

Documentation for Immediate Jeopardy should follow the Principles of Documentation. The following are examples of HCFA-2567's documenting Immediate Jeopardy.

Example for LTC: Failure to Prevent Abuse

F223 483(b) Requirements
ABUSE

Scope and Severity B Level is J.-- The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

This requirement is not met as evidenced by the following:

Based on interview, and record reviews, it was determined the facility failed to assure that the female residents on the North Wing had an environment that was free from sexual abuse. The findings constituted an Immediate Jeopardy situation. Facility staff had knowledge of the inappropriate sexual behaviors of two male residents (Residents #12 and 27). The facility had not consistently identified the victims, had not conducted investigations, and had not implemented effective preventive measures to protect the female residents on North Wing from actual and potential sexual abuse. There were multiple incidents of actual harm with three identified sample residents (Residents #3, 14, and 25). There were three incidents of potential harm for three unidentified residents.

Findings include.--

1. A review of Resident #12's record revealed a nurse's note dated xx/xx/xx, at 1:30 a.m., the resident was found sitting next to Resident #3 in the common area. Resident #12 had "one hand on [Resident #3's] buttock and one hand on the breast. [Resident #3] was attempting to push Resident #12's hand away." At 4:00 a.m., the same day, Resident #12 was found in the hallway with hands on an unidentified, nude female resident.

2. Resident #12 record revealed that on xx/xx/xx, at 11:30 p.m., the resident was found in an unidentified female resident's bed with both side rails up. Resident #12 had one hand directly on the female's labia. The female resident was unable to respond. The nurses notes dated xx/xx/xx, stated, "Resident #12 was sexually inappropriate with a female resident who could not give consent."

3. On xx/xx/xx, at 7:15 p.m., a nurses note in Resident #12's record stated that the resident was found standing in the hall, behind Resident #14, who was sitting in a wheelchair. Resident #12's hands were on Resident #14's breast. Resident #14 stated, "I am going to call the police."

4. Interview with the Administrator and DON on xx/xx/xx, confirmed that none of the incidents involving Resident #12 had been reported to the State per the State's complaint protocol.

5. On xx/xx/xx at 3:30 a.m., Resident #27's record revealed the resident was found in the room of Resident #25 (a severely cognitively impaired resident, who was unable to communicate) standing by the bed, with pajama bottoms down and hands in Resident #25's genital area. An incident report, dated xx/xx/xx revealed Resident #25 "looked frightened, with widened eyes, unable to defend self or call for help."

6. Nurses notes dated xx/xx/xx, at 10:30 p.m., revealed Resident #27 was found in an unidentified resident's room, with the covers pulled back, and hands in the resident's genital area.

7. There were no incident reports for xx/xx/xx or xx/xx/xx for Resident #27. Interview with the charge nurse on xx/xx/xx, revealed that she had no knowledge of the incidents, whether an investigation of the incidents had been conducted, or if efforts had been made to protect female residents.

Example for All Other Entities with Conditions of Participation or Conditions of Coverage: Failure to provide safety from fire, smoke and environmental hazards and/or failure to educate staff in handling emergency situations

I 117 485.723 Condition
PHYSICAL ENVIRONMENT

The building housing the organization is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public and provides a functional, sanitary, and comfortable environment.

This Condition is not met as evidenced by the following:

Based on observation, interview and review of policies and procedures, the agency failed to assure patients were protected from fire hazards, failed to provide adequate egress for emergencies (refer to I-118) and failed to provide adequate protection from hazardous chemicals (refer to I-158). These deficiencies resulted in potential harm for 20 of 20 sample patients (#1-20) and the 90 additional patients receiving care at the agency. An Immediate Jeopardy to the patients and the public was created by these deficiencies.

I-118 485.723(a) Standard
SAFETY OF PATIENTS

The organization satisfies the following requirements.--

1. It complies with all applicable State and local building, fire, and safety codes.

2. Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas of the organization considered to have special fire hazards. Fire extinguishers are conveniently located on each floor of the premises. Fire regulations are prominently posted.

3. Doorways, passageways, and stairwells negotiated by patients are:

a. Of adequate width to allow for easy movement of all patients (including those on stretchers or in wheelchairs);

b. Free from obstruction at all times;

c. In the case of stairwells, equipped with firmly attached handrails on at least one side;

d. Lights are placed at exits and in corridors used by patients and are to be supported by an emergency power source;

e. A fire alarm system with local alarm capability and, where applicable, an emergency power source is functional;

f. At least two persons are on duty on the premises of the organization whenever a patient is being treated; and

g. No occupancies or activities undesirable or injurious to the health and safety of patients are located in the building.

This Standard is not met as evidenced by the following:

Based on an observation and interview, the agency failed to provide unobstructed hallways and exits for 1 of 2 exit doors and hallways; failed to provide adequate maintenance of exit lighting for 1 of 2 exits and 2 of 4 emergency lights; and failed to provide a fire alarm system; resulting in the potential harm for all the agency's current patients including 20 of 20 sample patients (#1-20). This resulted in an Immediate Jeopardy.

Findings Include.--

1. Observation of the passageway on xx/xx/xx at 3 p.m. and on xx/xx/xx at 10 a.m., revealed that the east hallway was partially obstructed with several items of furniture and other obstacles. During interview, at 11 a.m. on xx/xx/xx, the administrator stated that the building manager was temporarily storing these items in the hallway. The administrator was unable to provide a date when the items might be relocated.

2. Observation at 12 noon on xx/xx/xx, revealed that the exercise pool for the agency was located in the basement in a windowless room. The room had two exit doors, located at opposite ends of the pool with narrow walkways on each side of the pool. One of the emergency exit signs above the door was not illuminated. The other exit door, with the illuminated emergency light, was locked. Four small battery powered flashlights had been placed throughout the room. Two of the four lights failed to illuminate when activated. The two remaining lights, when activated, failed to provide adequate lighting to allow visibility for egress.

3. Review of the agency's policies and procedures indicated that, in case of fire, employees were to pull the manual alarm. Interview with staff during the survey revealed that seven of the seven staff members on duty were unable to identify where the pull alarm was located. Observation on xx/xx/xx at 10 a.m. failed to provide any evidence of a fire alarm. During interview with the administrator on xx/xx/xx at 12 noon, the absence of a fire alarm was confirmed.

I 158 485.723(b) Standard
MAINTENANCE OF EQUIPMENT/BUILDINGS/GROUNDS

The organization establishes a written preventive maintenance program to ensure that:

1. The equipment is operative and is properly calibrated; and

2. The interior and exterior of the building are clean and orderly and maintained free of any defects that are a potential hazard to patients, personnel, and the public.

This Standard is not met as evidenced by the following:

Based on observation and review of the policies and procedures, the agency failed to provide preventative maintenance of the clothes dryer resulting in a potential fire hazard, and failed to properly store pool supplies resulting in a potential chemical hazard for 20 of 20 sample residents (#1-20) and all of the current patients. This resulted in Immediate Jeopardy.

Findings Include.--

1. Observation of the laundry room on xx/xx/xx at 12:50 a.m., revealed a large amount of dryer lint on top of the dryer and the water heater, behind the washer, dryers, and water heater, and covering the ceiling and the ceiling roof vent. The washing machine repairman, during interview on xx/xx/xx at 1 p.m., related the extent of the lint accumulation to a plugged dryer exhaust vent and stated that this was an "extreme fire hazard." The administrator was notified of the potential fire hazard on xx/xx/xx at 1:30 p.m.. The vent had not been cleaned, nor had the lint been removed by xx/xx/xx, even though the administrator had been notified of the potential hazard 2 days prior.

2. Observation of the storage area for pool supplies and equipment on xx/xx/xx at 2 p.m., revealed that the chlorine powder was stored in barrels with damaged lids which did not close properly. The chlorine powder had been spilled on the floor and had been tracked out into the pool area. Neither the storage area nor the pool area contained any hazardous chemical warnings. An interview with the pool maintenance staff on xx/xx/xx at 2:15 p.m, did not provide any evidence that the staff had been educated regarding the precautions for hazardous chemicals. The staff was unable to locate any policies or procedures regarding how employees should respond to a chemical spill.

OVERVIEW
RECOMMENDED KEY COMPONENTS
OF SYSTEMIC APPROACH TO PREVENT ABUSE AND NEGLECT

Examples--Key Components applied to the following provider types:

KEY COMPONENTS APPLICABLE TO ALL PROVIDERS		NURSING HOMES		ICFs/MR	
		Regulation Authority	Survey Guidance Surveyors determine if:	Regulation Authority	Survey Guidance Surveyors determine if:
1. **PREVENT**	**The facility or system has the capacity to prevent the occurrence of abuse and neglect and reviews specific incidents for "lessons learned" which form a feedback loop for necessary policy changes.**	483.13(b) 483.13(c) 483.13(c)(3)	The facility must develop and implement policies and procedures that include the seven key components: screening, training, prevention, identification, investigation, protection and reporting/response; the facility identifies, corrects and intervenes in situations in which abuse or neglect is more likely to occur, and the facility identifies characteristics of physical environment and deployment of staff and residents (e.g., those with aggressive behaviors) likely to precipitate abuse or neglect.	483.420(a)(5) 483.420(d)(1) 483.420(d)(1)(I)	The facility has and implements abuse prevention policies and procedures; and the facility organizes itself in such a manner that individuals are free from threat to their health and safety.

OVERVIEW
RECOMMENDED KEY COMPONENTS
OF SYSTEMIC APPROACH TO PREVENT ABUSE AND NEGLECT

Examples--Key Components applied to the following provider types:

KEY COMPONENTS APPLICABLE TO ALL PROVIDERS		NURSING HOMES		ICFs/MR	
		Regulation Authority	Survey Guidance Surveyors determine if:	Regulation Authority	Survey Guidance Surveyors determine if:
2. **SCREEN**	**The facility or system provides evidence and maintains efforts to determine if persons hired have records of abuse or neglect.**	483.13(c)(1)(ii) (A)&(B)	The facility screens potential employees for a history of abuse, neglect, or mistreating residents as defined by the applicable requirements.	483.420()(1)(iii)	The facility screens potential employees to prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect, or mistreatment.
3. **IDENTIFY**	**The facility or system creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect.**	483.13(c)(2)	The facility identifies events such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse; and determine the direction of the investigation.	483.420(a)(5)	The facility identifies patterns or isolated incidents of unexplained functional regression, or other evidence of physical, verbal, sexual or psychological abuse or punishment posing a serious and immediate threat to individuals.

OVERVIEW
RECOMMENDED KEY COMPONENTS
OF SYSTEMIC APPROACH TO PREVENT ABUSE AND NEGLECT

Examples--Key Components applied to the following provider types:

KEY COMPONENTS APPLICABLE TO ALL PROVIDERS		NURSING HOMES		ICFs/MR	
		Regulation Authority	Survey Guidance Surveyors determine if:	Regulation Authority	Survey Guidance Surveyors determine if:
4. **TRAIN**	**The facility or system, during its orientation program, and through an ongoing training program, provides all employees with information regarding abuse and neglect and related reporting requirements, including prevention, intervention and detection.**	483.74(e)	The facility has procedures to train employees, through orientation and on-going sessions, on issues related to abuse prohibition practices.	483.420(d)(1) 483.430(e)(1)	Facility ensures that staff can define what constitutes abuse and punishment and actively promotes respect for individuals; and facility assures that staff have received training, both upon hiring and on an ongoing basis, which results in the competencies needed to do their job.
5. **PROTECT**	**The facility or system must protect individuals from abuse and neglect during investigation of any allegations of abuse or neglect.**	483.13(c)(3)	The facility has procedures to protect residents from harm during an investigation.	483.430(d)(3)	The facility prevents further potential abuse while the investigation is in progress.
6. **INVESTIGATE**	**The facility or system ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect, or mistreatment.**	483.13(c)(2)(3)&(4)	The facility has procedures to investigate different types of abuse; and identify staff member responsible for the initial reporting of results to the proper authorities.	483.420(d)(3)	The facility investigates all injuries of unknown origin and allegations of mistreatment, neglect, or abuse.

OVERVIEW
RECOMMENDED KEY COMPONENTS
OF SYSTEMIC APPROACH TO PREVENT ABUSE AND NEGLECT

Examples--Key Components applied to the following provider types:

KEY COMPONENTS APPLICABLE TO ALL PROVIDERS		NURSING HOMES		ICFs/MR	
		Regulation Authority	Survey Guidance Surveyors determine if:	Regulation Authority	Survey Guidance Surveyors determine if:
7. **REPORT/ RESPOND**	**The facility or system must assure that any incidents of substantiated abuse and neglect are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State or Federal law.**	483.13(c)(1)(iii) 483.13(c)(2) 483.13(c)(4)	The facility has procedures to report all alleged violations and substantiated incidents to the State agency and to all other agencies, as required, and to take all necessary corrective actions, depending on the results of the investigation; report to State nurse aide registry or licensing authorities any knowledge it has of any action by a court of law which would indicate an employee is unfit for service, and analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.	483.420(1)(6) 483.420(d)(2) 483.420(d)(4)	The results of all investigations are reported to the administrator or designated representative or to other officials in accordance with State law within 5 working days of the incident and, if the alleged violation is verified, appropriate corrective action is taken.

APPENDIX R

RESIDENT ASSESSMENT INSTRUMENT

FOR LONG TERM CARE FACILITIES

APPENDIX R

RESIDENT ASSESSMENT INSTRUMENT FOR LONG TERM CARE FACILITIES

INTRODUCTION

PART I
Utilization Guidelines for Completion of the Resident Assessment Instrument

PART II
Minimum Data Set, Quarterly Review and Correction Request

PART III
Utilization Guidelines Pertaining to The Resident Assessment Protocols

PART IV
Minimum Data Set
Automation, Electronic Transmission, and Correction Guidelines

INTRODUCTION

Sections 1819(f)(6) and 1919(f)(6) of the Social Security Act (the Act) require that the Secretary specify a minimum data set (MDS) of core elements and common definitions for use by long term care facilities in conducting comprehensive assessments of residents residing in long term care facilities. These sections also require the Secretary to establish guidelines for the use of these data elements. These utilization guidelines consist of instructions for using the Resident Assessment Instrument (RAI) and include the resident assessment protocols (RAPs). Furthermore, the Secretary is required to designate one or more RAIs which are consistent with the MDS and common definitions. A State may specify the RAI designated by the Secretary for use in conducting assessments, or it may develop an alternate RAI provided it is approved by the Secretary as being consistent with the MDS of core elements, common definitions and utilization guidelines.

HCFA's original RAI was published in 1990 and implemented in all States by 1991. HCFA subsequently undertook a collaborative process to revise the RAI, which culminated in the release of version 2.0 of the RAI.

This transmittal serves as HCFA's means of redesignating the RAI and requiring the use of the September, 2000 update of version 2.0 of the RAI (or an approved alternate) by all States. As such, each State's RAI must consist of at least HCFA's September, 2000 RAI. Any State-specific items are included in an optional Section S. States may also specify the standardized, optional sections T and U as part of their RAI.

Version 2.0 of the RAI is comprised of the utilization guidelines included in Part I of this appendix; the MDS, Quarterly review, and Correction Request Form in Part II; and the utilization guidelines pertaining to the RAPs in Part III. Corresponding instructional materials are included in each part. The guidelines for encoding, correcting and electronically transmitting RAI information to the State are included in Part IV.

Under the SNF PPS requirements, facilities must complete Section T for residents in a Medicare Part A covered stay each time an MDS is required for Medicare payment purposes.

PART I UTILIZATION GUIDELINES FOR COMPLETION OF THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

Include the following guidelines with any assessment instrument provided to long term care facilities.

A. General Guidelines.--

1. Use of The Assessment.--

a. Clinical.--Use the RAI to comprehensively assess all residents, regardless of payor source, in long term care facilities certified to participate in Medicare or Medicaid. The RAI gathers information on the resident's condition, helps develop an individualized care plan, and enables a facility to track changes in resident status.

Adhere to the MDS definitions specified in Part I. In addition to direct observation and communication with the resident, use a variety of information sources to complete the assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

Other sources of information may include, but are not limited to:

- Discussion of the resident's status with an attending physician;

- Discussion of the resident's status with family members;

- Discussion of the resident's status with appropriate licensed health professionals who have observed, evaluated, and/or treated the resident; and/or

- The resident's record, including the admission record, physician's orders, plan of care, documentation of services provided to the resident, reports of any diagnostic testing, consultation, or other services, medications administration record, copies of any transfer data provided by another health care facility, and summaries of previous discharges.

While the MDS is primarily a tool for clinicians to use in care planning, many MDS items are also used to determine the Resource Utilization Group (RUG III) for residents in a Part A Medicare stay.

2. Coordination of the Assessment.--A registered nurse is responsible for conducting or coordinating each resident assessment. This person's responsibilities may include:

- Using instructional materials, including the utilization guidelines prepared by HCFA, to train other facility staff to gather information, and to instruct them of circumstances which require that an assessment be completed;

- Delegating responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses, social workers, activities specialists, physical, occupational, or speech therapists, attending physicians, dietitians, and pharmacists;

- Establishing facility policies and procedures to assure that key clinical personnel on all shifts are knowledgeable about the information found in the resident's most current assessment, and report changes in resident's status that may affect the accuracy of this information; or

- Establishing facility policies and procedures that instruct staff how to integrate MDS information with existing facility resident assessment and care planning practices.

3. Certification of Completion and Accuracy.--Have the registered nurse coordinating the assessment sign, date and certify the completion of the MDS and RAPs. Each individual who completes a portion of the MDS assessment must indicate which portions he or she completed and must certify the accuracy of that portion of the assessment. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement is subject to civil money penalties. Clinical disagreement does not constitute a material and false statement. Civil and criminal statutes impose liability on persons or entities for knowingly submitting false or for knowingly and willfully making false statements. They do not impose liability for innocent acts or for mistakes. For the purpose of the Federal Civil False Claims Act, Congress defined the term "knowingly" to include not only acting with "actual knowledge" of the truth or falsity of information, but also acting with "reckless disregard" or "deliberate ignorance" of the truth or falsity of information.

4. Guidelines for Maintaining Assessment Information.--Place all completed resident assessments (i.e., all full MDS forms, all quarterly review forms, all RAP Summary Forms and RAP documentation, Face Sheet information, and Discharge and Reentry Tracking forms) in the resident's record. Maintain all resident assessments completed within the last 15 months on each resident's record. The one exception is for Face Sheet information, which is a permanent part of the clinical record, and as such, is to remain in the active record for all current residents, for the duration of their stay. A copy of the Face Sheet information is to be brought forward from the closed to the active record when a resident returns from a discharge. If a resident is permanently discharged, (without expectation of return), and then comes back to the facility, a new Face Sheet must be completed. Assessment data need not be stored in one binder. For example, facilities may choose to maintain assessment and care planning information in a separate binder or kardex system, as long as the information is kept in a centralized location and is accessible to all staff who need to review the information in order to provide care to the resident.

B. Frequency of Assessment.--Federal requirements mandate that long term care facilities perform a comprehensive assessment of residents using the RAI specified by the State:

- Within 14 days of admission to the facility;
- Promptly after a significant change in the resident's physical or mental condition; and
- In no case, less often than once every 12 months.

In addition, the facility must assess each resident no less frequently than once every 3 months and, as appropriate, revise the resident's care plan. In doing so, the facility must use the quarterly review specified by the State and approved by HCFA.

Following are specific utilization guidelines for conducting comprehensive assessments and quarterly reviews:

1. At Admission.--Conduct an assessment within 14 days of admission if this is the resident's first stay in the facility or if the resident returns to the facility after he or she was discharged with no expectation of return.

Facilities are not required to reassess the resident if he or she is readmitted unless a significant change has occurred. A readmission is defined as a return to the facility following a temporary absence for hospitalization or for therapeutic leave. If a significant change in status has occurred, use the procedures which follow for conducting a significant change reassessment.

2. At a Significant Change in a Resident's Status.--A "significant change" is defined as a major decline or improvement in the resident's status that:

- Will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions;
- Impacts on more than one area of the resident's health status; and
- Requires interdisciplinary review and/or revision of the care plan.

For example, normally a five percent weight loss would trigger a significant change reassessment. However, if a resident had the flu and experienced nausea and diarrhea for a week, a 5 percent weight loss may be an expected outcome. In this case, staff should monitor the resident's status. If the resident did not become dehydrated and started to regain weight after the symptoms subsided,

a comprehensive assessment would not be required. The amount of time that would be appropriate for a facility to monitor a resident depends on the clinical situation and severity of symptoms experienced by the resident. Generally, if the condition has not resolved within approximately two weeks, staff should begin a comprehensive reassessment. This timeframe is not meant to be prescriptive but rather, should be driven by clinical judgment and the resident's needs.

A comprehensive significant change reassessment is required if decline or improvement are consistently noted in two or more areas of decline, or two or more areas of improvement.

3. Decline.--

- Any decline in Activities of Daily Living (ADL) physical functioning where a resident is newly coded as 3, 4 or 8 (Extensive Assistance, Total Dependency, Activity Did Not Occur);

- Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1's" for E4B);

- Resident's decision-making changes from 0 or 1 to 2 or 3;

- Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4, or placement of an indwelling catheter;

- Emergence of sad or anxious mood as a problem that is not easily altered;

- Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);

- Begin to use trunk restraint or a chair that prevents rising for a resident when it was not used before;

- Emergence of a condition/disease in which a resident is judged to be unstable;

- Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher; or

- Overall deterioration of resident's condition; resident receives more support (e.g., in ADLs or decision-making).

4. Improvement.--

- Any improvement in ADL physical functioning where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8;

- Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered";

- Resident's decision-making changes from 2 or 3 to 0 or 1;

- Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1; or

- Overall improvement of resident's condition; resident receives fewer supports.

This list is not exhaustive, as other situations may also meet the significant change definition. In an end-stage disease status, a significant change reassessment is optional, depending on a clinical determination of whether the resident would benefit from it.

Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes.

Complete a comprehensive assessment as soon as needed to provide appropriate care to the individual, but in no case later than 14 days after determining a significant change has occurred.

It is not necessary to complete a significant change assessment if declines in a resident's physical, mental, or psychosocial well-being are attributable to:

o Discrete and easily reversible cause(s) documented in the resident's record and for which facility staff can initiate corrective action, e.g., an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require a significant change reassessment;

o Short-term acute illness such as a mild fever secondary to a cold from which facility staff expect the resident to fully recover; or

o Well-established, predictive cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a significant change reassessment.

5. At Least Annually.--Each resident must have a comprehensive assessment no later than 12 months following the last–comprehensive assessment. Whenever a comprehensive assessment is performed due to a significant change or significant correction of prior full assessment, the 12-month "clock" starts over.

6. Quarterly Reviews.--To track resident status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status, assess the following key MDS elements for all residents quarterly using the State-specified form. In conducting quarterly reviews, facilities must also assess any additional items required for use by the State. The facility must complete Section AA, Identification Information, in addition to the items listed below:

- o Section A: Identification and Background Information:
  - Item 1 (Resident Name);
  - Item 2 (Room Number);
  - Item 3 (Assessment Reference Date);
  - Item 4 (Date of Readmission); and
  - Item 6 (Medical Record Number).
- o Section B: Cognitive Patterns:
  - Item 1 (Comatose);
  - Item 2 (Memory);

- Item 4 (Cognitive Skills for Daily Decision-making); and
- Item 5 (Indicators of Delirium--Periodic Disordered Thinking/Awareness).

o Section C: Communication/Hearing Patterns:

- Item 4 (Making Self Understood); and
- Item 6 (Ability to Understand Others).

o Section E: Mood and Behavior Patterns:

- Item 1 (Indicators of Depression, Anxiety, Sad Mood);
- Item 2 (Mood Persistence); and
- Item 4 (Behavioral Symptoms).

o Section G: Physical Functioning and Structural Problems:

- Item 1 (ADL Self-Performance);
- Item 2 (Bathing);
- Item 4 (Functional Limitation in Range of Motion); and
- Items 6a, b, and f (Modes of Transfer).

o Section H: Continence in Last 14 Days:

- Item 1 (Continence Self-Control);
- Items 2d and e (Bowel Elimination Pattern); and
- Items 3a, b, c, d, i and j (Appliances and Programs).

o Section I: Disease Diagnoses:

- Items 2j and m (Infections); and
- Item 3 Disease Diagnoses.

Using the ICD-9-CM coding system, note only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death.

o Section J: Health Conditions:

- Items 1c, i, and p (Problem Conditions);
- Item 2 (Pain Symptoms);

- Item 4 (Accidents); and
- Item 5 (Stability of Conditions).

o Section K: Oral/Nutritional Status:

- Item 3 (Weight Change); and
- Items 5b, h and i (Nutritional Approaches).

o Section M: Skin Condition:

- Item 1 (Ulcers); and
- Item 2 (Type of Ulcer).

o Section N: Activity Pursuit Patterns:

- Item 1 (Time Awake); and
- Item 2 (Average Time Involved in Activities).

o Section O: Medications:

- Item 1 (Number of Medications); and
- Item 4 (Days Received the Following Medications).

o Section P:

- Item 4 (Devices and Restraints).

o Section Q: Discharge Potential:

- Item 2 (Overall Change in Care Needs)

o Section R: Assessment/Discharge Information:

- Item 2 (Signature of Person Coordinating the Assessment).

Based on the quarterly review, revise the care plan if indicated.

PART II - MINIMUM DATA SET (MDS)

The following rules apply to HCFA's RAI, Version 2.0, as used by all long-term care facilities certified to participate in Medicare or Medicaid.

1. Content of the Minimum Data Set (MDS) Version 2.0 for Nursing Home Resident Assessment and Care Screening is Recorded on the Following Mandated Forms.--In addition to the forms for identification (Section AA) and background information (Sections AB, AC and AD), 19 sections, lettered from A to R and V, comprise the MDS. Each section contains one or more items labeled sequentially and corresponding definitions. For instance, the third item in Section B is labeled "B3", the fifth item in Section P is "P5".

Answer boxes differ by the type of response required for the MDS item. Annotate those items with a letter in the answer box with a check mark. For items which have a blank box, enter either a number, such as height or weight, or a pre-assigned code. Leave darkly shaded boxes blank. Answer all items unless the instructions tell you to skip over the next item (or several items). Leave skipped items blank. When responding to these items, follow the sequence as closely as possible. In cases where information is unavailable and despite continued investigation, the information WILL REMAIN UNAVAILABLE OR UNKNOWN, enter the code "NA" or a circled dash. When the MDS is entered into the computer the "NA" or a circled dash will be entered as a dash ("-").

A. The Basic Assessment Tracking Form.--This form contains Section AA (Identification Information) Items 1-9, which consists of identifying information needed to uniquely identify each resident, the home in which he or she resides, the reason(s) for assessment; and Items AA9 a-l, Signatures of Persons Completing a Portion of The Assessment or Tracking form, Sections AA and A - V, (including Sections T and U). It is particularly important that identifying information is complete and accurate. Refer to Correction Policy (Part IV of Appendix R) for information concerning the process of correcting erroneous key information in a locked record.

The information contained on this form must accompany each Comprehensive, Full or Quarterly Assessment submitted electronically to the State MDS database. This includes Federally-required assessment records (e.g., *Admission, Annual, Significant Change in Status, and Quarterly Assessments)*, as well as assessments required for Medicare PPS or by the State. The Discharge and Reentry Tracking Forms have been developed to also contain the identifying information found on the Basic Assessment Tracking Form, as well as signatures of Persons Completing a Portion of the Assessment or Tracking Form. This information is required to be submitted with either the Discharge or Reentry Tracking Form.

B. Background (Face Sheet) Information at Admission Form.--This form contains Sections AB (Demographic Information), Section AC (Customary Routine), and Section AD (Face Sheet Signatures). This information is to be completed at the time of the resident's initial admission to the nursing home. A new Face Sheet is also required to be completed, along with an Initial Admission assessment, for an individual who returns to the facility after a discharge in which return was not anticipated. HCFA's clinical policies, as well as data specifications, allow Face Sheet information to be updated and submitted after the admission assessment is completed and transmitted. This means that Face Sheet information can be transmitted with any of the Federally-required records (those indicated by the codes under AA8a) or the assessments required for Medicare PPS (those indicated by the codes under AA8b). The only instance in which Face Sheet information cannot be updated is from those assessments required by the State (AA8a = "0" and AA8b = "6").

If Face Sheet information was completed for residents admitted prior to implementation of version 2.0 use the information from the original Face Sheet to complete the version 2.0 Face Sheet. Three new items appear on the version 2.0 Face Sheet, including items AB2 "Admitted From (At Entry)", AB4 "Zip Code of Prior Primary Residence," and AB7 "Education". These items should be completed prior to submission, if the information is obtainable. Use the standard "no information" code (circled dash or "NA") where, despite exhaustive probing, the information is not available.

If there is no Face Sheet information for a resident, complete as many version 2.0 Face Sheet items as can be completed. Some information, such as customary routine, may not be known or obtainable. Use the standard "no information" code (circled dash or "NA") where information is unobtainable.

C. Full Assessment Form.--This form contains Sections A (Identification and Background Information) through Section R (Assessment Information). Completion of the *Full Assessment* form is required more frequently for those residents whose stay is being paid by Medicare Part A. Section T (Therapy Supplement for Medicare PPS) is required for residents whose stay is covered by Medicare Part A any time completion of a Medicare PPS assessment is required.

Some States may also require assessments to be conducted outside of the schedule of Federally-required assessments for payment or quality monitoring purposes. Contact your State RAI representative if you have any questions about when assessments are required. Additional MDS items (if any) required by your State appear in Section S. States may also require facilities to complete Sections T (Therapy Supplement) or U (Medication Information) for all residents.

D. Comprehensive Assessment.--By statute, a comprehensive assessment (the full MDS assessment form, RAPs, and care plan review) must be completed on admission, annually, and at the time of significant change in resident status. Facilities are required to complete the RAI within 14 days of admission, no later than within 14 days of a significant change in a resident's status and at least annually. The RAI must also be completed within 14 days of the identification of a major, uncorrected error in a prior, comprehensive assessment. In this case, the primary reason for assessment (MDS Item AA 8a) is coded 4, "Significant Correction of Prior Full Assessment". The registered nurse must sign and date the RAP Summary Form to signify that the assessment is complete. The dates on the MDS and RAP Summary Form must be within required timeframes (i.e., within 14 days of admission and annually) or within 14 days of determining a significant change in status or identifying a major, uncorrected error in a prior, comprehensive assessment. Facilities remain responsible for providing necessary care and services while completing the assessment documentation.

E. MDS Version 2.0 Quarterly Assessment Form.--This two page form contains a mandated subset of MDS items from Section A (Identification and Background Information) through Section R (Assessment Information) that serves as the minimum requirement for quarterly assessment within each State's RAI. The Quarterly Assessment is to be completed no less frequently than once every 3 months between comprehensive assessments. The quarterly assessment must also be completed within 14 days of the identification of a major, uncorrected error in a prior quarterly assessment. In this case, the primary reason for assessment (MDS Item AA8a) is coded 10, "Significant Correction of Prior Quarterly Assessment".

Some States have mandated an expanded *Optional Quarterly Assessment Form.* HCFA has published two optional versions that States may require: the three page MDS Quarterly Assessment Form (Optional Version for RUG III) or the three page MDS Quarterly Assessment Form (Optional Version for Resource Utilization Groups (RUGs) (RUG III 1997 Update). A State may also specify

a full assessment on a quarterly basis (or any set of MDS items that, as a minimum, include those on the standard 2 page quarterly assessment form, with the addition of other MDS items up to and including the full assessment, with or without RAPs or with or without sections S, T and/or U.)

F. RAP Summary Form.--Considered Section V of the MDS, this form is used to document triggered RAPs, the location of documentation describing the resident's clinical status and factors that impact the care planning decision, and whether a care plan has been developed for each RAP area. Note that the RAP need not have triggered for a care plan to be developed for that particular area. A *RAP Summary Form* must be completed each time a comprehensive RAI is required under the Federal schedule.

Some States require completion of the full MDS each quarter or more frequently for payment or quality monitoring purposes. Generally, the RAP Summary Form does not need to be completed on these occasions, unless specifically directed by the State. Check with your State to determine if RAPs are required for any State-required assessments.

G. MDS Correction Request Form.--This form is part of Correction Policy, which provides a mechanism for facility-driven electronic corrections to erroneous information that has been previously submitted and accepted into the MDS database at the State. This form must be completed by the facility, in accordance with the guidelines for Correction Policy in Part IV of Appendix R, within 14 days of detecting an inaccuracy in an MDS record (assessment, Discharge or Reentry Tracking Form) that resides in the MDS database at the State. This form should only be used to request corrections to records that actually have been accepted and reside in the State database. The standard MDS system at the State will not recognize and will reject a correction request for a record that has not yet been submitted, or for a record that has been submitted, but rejected. The MDS Correction Request Form contains a Prior Record Section and a Correction Attestation Section. The Prior Record Section contains Items Prior AA1 - Prior AA3, Prior AA5, Prior AA8, Prior A3, Prior R4, and Prior A4a. Information in this Section is reproduced exactly as it appeared in the corresponding items on the prior, erroneous record, and is necessary in order to locate the erroneous record in the State database. The Correction Attestation Section contains Items AT1-AT7. This Section provides a mechanism to describe the reason for the correction request; identify the action required (modification or inactivation); and attest to the accuracy of the Correction Request Form, as well as the corrected information.

2. Discharge and Reentry Tracking Forms.--Facilities are required to submit the information contained on two additional forms to notify the State if a resident is "discharged" or "reenters" the MDS system. Both the *Discharge Tracking Form* and the *Reentry Tracking Form* contain Section AA (Identification Information) Items 1 through 7, a subset of codes from Item 8 (Reason for Assessment), and Item 9. The *Discharge Tracking Form* also contains items from Section R related to discharge status and date, along with two items that are required only for individuals whose stay is less than 14 days. The *Reentry Tracking Form* contains items from Section A related to the date and point of reentry. States may opt to require Section S information to accompany Discharge and Reentry Tracking forms.

A. The Discharge Tracking Form.--This form includes Section AA (Identification Information) Items 1-9, but *only the 3 discharge codes from Item 8, Reason for Assessment.* It also contains Items AB1-2, A6, and R3-4. This form must be completed when the resident dies or leaves the facility and is actually admitted to another health care facility, regardless of whether the long-term care facility formally discharges the resident. For example, a resident may be admitted to the hospital for a 3-day stay, but never discharged from the facility. In that case, the D*ischarge Tracking Form* must be completed. An exception to this requirement is when the resident is on a temporary visit home or another type of therapeutic or social leave. This requirement also does not apply to observational stays of less than 24 hours when the resident is not admitted to the hospital.

The requirement for completing the *Discharge Tracking Form* applies regardless of a facility's policy and procedure for discharge or opening and closing records, and regardless of how long the individual was a resident of the facility. Note that HCFA's definition of discharge may differ from your facility's own definition of discharge. Because there is so much variation in bed hold policies across States and facilities, HCFA was compelled to create a uniform way of defining discharge for the national assessment system.

The Discharge Tracking Form must be completed within 7 days of the date at MDS Item R4 (Discharge Date).

The Discharge Tracking Form must always be completed whenever the resident is formally discharged from the facility. There are two separate codes that differentiate whether or not the resident is expected to return to the facility. There is not a requirement to track the resident's status once a discharge form has been completed (whether or not return was anticipated) so there is not a Federal requirement for submission of additional information to the State, unless the resident returns to the facility.

Facilities must complete and submit to the State database, information on the Discharge Tracking Form for all individuals that have been admitted to the facility and then die, or are discharged for reasons other than a temporary visit home, regardless of how short the stay is. For individuals who have been discharged prior to the 14th day of their stay, and for whom an admission assessment was not completed, the facility must complete the two additional items on the Discharge Tracking Form, and use the code "8" at AA8a indicating "Discharged prior to completing initial assessment". The Discharge Tracking Form is the only form that must always be completed at the time of any discharge from the nursing home. Most of the items on the form are not clinical in nature, and can be completed by clerical staff. However, clinical staff should note the appropriate "Reason for Assessment" by entering a code of either "6. Discharged-return not anticipated;" "7. Discharged-return anticipated;" or "8. Discharged prior to completing initial assessment," for Item AA8a on the *Discharge Tracking Form.*

Refer to the "MDS 2.0 Discharge and Reentry Flowchart" (Exhibit 260) for more detailed guidance regarding when Discharge Tracking forms are required.

B. The Reentry Tracking Form.--This form includes Section AA (Identification Information) Items 1-9, but only one code (designating "Reentry") from Item 8, Reason for Assessment. It also contains Items A4a and b, and A6. This form is completed whenever a resident reenters the nursing home following temporary admission to a hospital or other health care setting, even if the resident's clinical record was not formally closed, and regardless of whether the resident was formally discharged from the facility. In this case, the facility should have submitted a Discharge Tracking Form when the individual was admitted to the other care setting. The State system must receive the Reentry tracking information in order to enter the resident back into the State database. The Reentry Tracking Form is the only form that must always be completed at the time of reentry to the facility following a temporary admission to a hospital or other health care setting. If the resident is discharged with return not anticipated, and then returns to the facility, a Reentry Tracking Form is not required. In this scenario, the resident is treated as a new admission and a new admission assessment is required.

The Reentry Tracking Form must be completed within 7 days of the date at MDS Item A4a (date of reentry).

There is one condition under which other forms shall accompany a *Reentry Tracking Form.* If the resident reenters the nursing home following a temporary admission to a hospital or other health care setting AND also meets significant change criteria, a comprehensive assessment must be completed,

which includes the MDS and RAPS. In this case, the facility should complete and submit a record for a *Reentry Tracking Form*, and a second record including a *Basic Assessment Tracking Form*, and a comprehensive assessment (with MDS Item AA8a coded as 3, significant change). In this scenario, enter a code of "9," Reentry for MDS Item AA8a (Reason for Assessment) on the Reentry Tracking Form; enter a code of "3," Significant Form; enter a code of "3," Significant Change Assessment for MDS Item AA8a (Reason for Assessment) on both the *Basic Assessment Tracking Form* and the *Full Assessment* Form. Completion of a Full Assessment may also be required by the State for payment purposes at times other than those required by Federal regulations at CFR Part 483.20.

Refer to the "MDS 2.0 Discharge and Reentry Flowchart" (Exhibit 260) for more detailed guidance regarding when Discharge Tracking forms are required.

3. The "Reason for Assessment" codes under MDS Items AA8a and A8a designate assessments required by Federal regulations related to comprehensive assessment. The codes under AA8b and A8b designate assessments required under Medicare PPS for patients whose stay is covered by Medicare, or by the State. Please note that there is no relationship between the codes in 8a and 8b, and that it is possible to select a code from both A8a or AA8a (Primary Reason for Assessment) and A8b or AA8b (Codes for Assessments Required for Medicare PPS or the State). For example, an individual receiving rehabilitation covered by Medicare may develop an acute condition, and be hospitalized. Upon return to the facility, a significant change in status assessment (A8a or AA8a=3) may be required if the individual meets the HCFA clinical criteria for a significant change. If a Medicare readmission/return assessment is also required (A8b or AA8b=5), a single assessment (with AA8a=3 and AA8b=5) can fulfill both requirements. The types of assessments and their corresponding reason for assessment codes are defined as follows:

o Admission Assessment, (Code 1).--In order to be in compliance with the requirements for Medicare or Medicaid certification, facilities must complete an Initial Admission Assessment, which is a comprehensive assessment including the MDS and the RAPs, within 14 days of a resident's admission to the facility. The facility may use either the Medicare 5-day or the Medicare 14-day assessment to meet the clinical requirement for completing and transmitting an Admission assessment provided it was completed as a comprehensive assessment (including MDS, RAPs and care plan). For example, if the Medicare 5-day assessment includes the RAPs, the "Primary Reason for Assessment" MDS item AA8a would be coded as an Admission assessment, and the MDS item AA8b would be coded as a Medicare 5 day assessment. If a facility is using the Medicare 14-day assessment to meet the Federal requirement for the Admission assessment, the assessment must be completed by day 14 of the resident's stay, regardless of the grace period that PPS rules permit.

o Annual Assessment, (Code 2).--A comprehensive reassessment required within 12 months of the most recent comprehensive assessment. If a resident is noted as having a significant change in status at the time of the annual assessment, use code "A8a=3" (significant change in status assessment); DO NOT code as an Annual Assessment.

o Significant Change in Status Assessment, (Code 3).--A comprehensive reassessment prompted by a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on the resident's health status, and requires interdisciplinary review or revision of the care plan, or both. When a resident experiences a significant change in status, the assessment must be completed by the end of the 14th calendar day following the date of determining that a significant change has occurred. The assessment clock is reset based on the completion date of the significant change in status assessment.

If, while completing a quarterly review assessment, it is noted that a significant change in status has occurred, facility staff should document the findings regarding significant change in the resident's clinical record, and proceed directly to completing a comprehensive assessment, rather than the quarterly review. The primary reason for assessment is to be coded as a significant change in status. In this case the comprehensive assessment satisfies the requirement for a quarterly review and the quarterly review does not need to be completed. The date of the significant change assessment may be later than the scheduled completion date of the quarterly review, because facility staff have until the end of the 14th calendar day following the date of determining that a significant change has occurred to complete the assessment.

o Significant Correction of Prior Full Assessment, (Code 4).--A new comprehensive assessment (including the full MDS form, RAPs and care plan review) is completed when an *uncorrected major error* is discovered in a prior comprehensive assessment (MDS Item AA8a=1,2,3 or 4). An error is *major* when the resident's overall clinical status has been miscoded on the MDS and/or the care plan derived from the erroneous assessment does not suit the resident. A *major error is uncorrected* when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan. A Significant Correction of Prior Full assessment that has already been accepted into the State MDS database, or in a comprehensive assessment that is no longer in the editing and revision process, having been completed 8 or more days ago (date at MDS item VB4), but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). It is not necessary to complete a new Significant Correction of Prior Full assessment if an assessment is already due or in progress that contains and will correct the item(s) in error.

A significant correction assessment uses a new observation period (as defined by a new Assessment Reference date). A significant correction assessment (not the original assessment that it corrects) drives the due date of the next assessment.

When the assessment in error has already been accepted by the MDS system at the State, in addition to completing a new assessment, (the Significant Correction assessment), the facility should also correct the assessment that was in error, by completing and submitting a correction request for the erroneous assessment. Refer to *Correction Policy for MDS Records* in the State Operations Manual, Appendix R, Part IV. It is necessary to correct the erroneous assessment that resides in the State MDS database in order to ensure that accurate information is available for reports that consider historic MDS information, such as incidence reporting for Quality Indicators.

The significant correction of prior full assessment differs from a significant change in status assessment, in which there has been an actual significant change in the resident's health status. In any instance in which a resident experiences a significant change in status, regardless of whether there was also an error on the previous assessment, the primary reason for assessment should be coded as a significant change in status. In the event of a significant change in status where there are also errors in a prior assessment already accepted into the State database, in addition to completing a significant change in status assessment, the facility should also correct the assessment that was in error by completing and submitting a correction request for that erroneous assessment.

o Quarterly Review Assessment, (Code 5).--The subset of MDS items required by the State which must be completed no less frequently than once every 3 months between comprehensive assessments. This assessment ensures that changes in the resident's status are noted, and can be incorporated into the care plan so that it remains current and meets the needs of the resident. If a significant change in status is noted at the time of a resident's quarterly review assessment, perform a comprehensive significant change in status assessment rather than a quarterly. Use code "A8a=3" (Significant Change in Status Assessment). DO NOT code as a Quarterly review assessment. In this case, a quarterly assessment need not be completed.

To minimize burden on facility staff, a full assessment that is completed to meet PPS requirements, may also be used to meet the clinical requirements at CFR Part 483.20 for completion of a Quarterly Review Assessment, as long as the Quarterly Review Assessment is completed no later than 92 days from the date at MDS Item R2b of the prior assessment, and the assessment includes at least the MDS items in the State-specified quarterly assessment. In this case, the "Primary Reason for Assessment" item on the assessment would be coded as a Quarterly Review Assessment (AA8a=5), and the Medicare reason for assessment at MDS Item AA8b would be coded appropriately.

o Discharged - Return Not Anticipated, (Code 6).--Use this code when a resident dies or is permanently discharged from a nursing home without the expectation that the resident will return. The following exception to HCFA's requirements for Discharge is allowable according to HCFA's standard edit specifications, but is not Federally required: A Discharge Tracking form that used code 7 (return anticipated) can be followed by an additional, subsequent Discharge tracking form using code 6 (return not specifications, but is not Federally required: A Discharge Tracking form that used code 7 (return anticipated) can be followed by an additional, subsequent Discharge tracking form using code 6 (return not anticipated), at the facility's option. This option can be used if, after the temporary discharge (with return anticipated), the facility gains knowledge that the resident will not return. Submission of a subsequent Discharge Tracking form may be required in some States for Medicaid program purposes.

o Discharged - Return Anticipated, (Code 7).--Use this code when a resident is temporarily discharged to a hospital (or other therapeutic setting). There is no federal requirement for a facility to track a resident following discharge, or to complete or submit an additional Discharge Tracking form when the likelihood of a resident's return changes after discharge. The facility is responsible for accurate coding of the Discharge Tracking form, including whether or not return is anticipated, based on what the facility knows to be true on the date of discharge. When the likelihood of return changes, subsequent to the discharge, the facility may at their option or per a State requirement, complete and submit an additional, subsequent Discharge Tracking form including current information regarding anticipation of return.

Inactivation of the original Discharge Tracking form and resubmission of the corrected information regarding anticipation of return is only appropriate when the facility can demonstrate that anticipation of return was, in fact, erroneously coded.

o Discharged Prior to Completing Initial Assessment, (Code 8).--Use this code when a resident dies or is discharged during the first 14 days of residency AND a comprehensive, Initial Admission assessment (including the full MDS form, RAPs and care plan review) has not been completed. In this case, the items in section AB on the discharge tracking form must also be completed.

o Reentry, (Code 9).--Use this code when a resident is readmitted after a temporary discharge to a hospital or other therapeutic setting.

o Significant Correction of Prior Quarterly Assessment, (Code 10).--A new Quarterly assessment is completed when an *uncorrected major error* is discovered in a prior Quarterly assessment. An error is *major* when the resident's overall clinical status has been miscoded on the MDS and/or the care plan derived from the erroneous assessment does not suit the resident. A *major error is uncorrected* when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan. A Significant Correction of Prior Quarterly assessment is appropriate when an *uncorrected major error* is present in a Quarterly assessment (MDS Item AA8a=5 or 10), that has already been accepted into the State

MDS database, or in a Quarterly assessment that is no longer in the editing and revision process, having been completed 8 or more days ago (date at MDS item VB4), but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). It is not necessary to complete a new Significant Correction of Prior Quarterly assessment if an assessment is already due or in progress that contains and will correct the item(s) in error.

A significant correction assessment uses a new observation period (as defined by a new Assessment Reference date). A significant correction assessment (not the original assessment that it corrects) drives the due date of the next assessment.

When the assessment in error has already been accepted by the MDS system at the State, in addition to completing a new assessment, (the Significant Correction assessment), the facility should also correct the assessment that was in error, by completing and submitting a correction request for the erroneous assessment. Refer to *Correction Policy for MDS Records* in the State Operations Manual, Appendix R, Part IV. It is necessary to correct the erroneous assessment that resides in the State MDS database in order to ensure that accurate information is available for reports that consider historic MDS information, such as incidence reporting for Quality Indicators.

- NONE OF ABOVE, (Code 0).--Use this code when none of the codes in A8a or AA8a apply, but the facility is required to complete an assessment for Medicare PPS or by the State (i.e., for the assessment types referenced in Item A8b or AA8b). If "0" is entered at A8a or AA8a, a code must be selected from the list of types of assessments at A8b or AA8b.

4. Assessments Required for Medicare PPS or the State.--All Medicare assessments require at least the full MDS form and Section T. The following codes under MDS Items AA8b and A8b, with the exception of code "6", designate assessments required under Medicare PPS for residents whose stay is covered by Medicare. The "Other State Required Assessment" (code "6") is for State required, off-cycle assessments. Some States require additional detail regarding the type of State required assessment, which is included in the State's Section S.

- Medicare 5-day assessment, (Code 1)
- Medicare 30-day assessment, (Code 2)
- Medicare 60-day assessment, (Code 3)
- Medicare 90-day assessment, (Code 4)
- Medicare Readmission/return assessment, (Code 5)
- Other State required assessment, (Code 6)
- Medicare 14-day assessment, (Code 7)
- Other Medicare required assessment, (Code 8)

Note that it is possible to select a code from both MDS Items A8a or AA8a and A8b or AA8b (e.g., Item A8a or AA8a coded "3" for a Significant Change in Status Assessment, and MDS Item A8b or AA8b coded "3" for a Medicare 60-day assessment).

In addition to the forms for identification (Section AA) and background information (Sections AB, AC and AD), 19 sections, lettered from A to R and V, comprise the MDS. Each section contains one or more items labeled sequentially and corresponding definitions. For instance, the third item in Section B is labeled "B3", the fifth item in Section P is "P5".

Answer boxes differ by the type of response required for the MDS item. Annotate those items with a letter in the answer box with a check mark. For items which have a blank box, enter either a number, such as height or weight, or a pre-assigned code. Leave darkly shaded boxes blank. Answer all items unless the instructions tell you to skip over the next item (or several items). Leave skipped items blank. When responding to these items, follow the sequence as closely as possible. In cases where information is unavailable and despite continued investigation, the information WILL REMAIN UNAVAILABLE OR UNKNOWN, enter the code "NA" or a circled dash. When the MDS is entered into the computer the "NA" or a circled dash will be entered as a dash ("-").

Facilities are required to complete the RAI within 14 days of admission, no later than within 14 days of a significant change in a resident's status and at least annually. The registered nurse must sign and date the RAP Summary Form to signify that the assessment is complete. The dates on the MDS and RAP Summary Form must be within required timeframes (i.e., within 14 days of admission and annually) or within 14 days of determining a significant change in status. Facilities remain responsible for providing necessary care and services while completing the assessment documentation.

The next 23 pages (pages R-15 through R-15.22) are reserved for the September 2000 Update of the RAI, version 2.0.

An electronic copy of the September 2000 RAI forms, a detailed description of the revisions to the forms, and implementation instructions are posted at the HCFA website at "http://www.hcfa.gov/medicaid/mds 20", under "Manuals and Forms", then under "MDS 2.0 RAI", then under "Forms:" then "September 2000 Update to the MDS Resident Assessment Form. There are several download files in this section, including a file named MDS0900b.pdf. This file includes an electronic copy of all the September 2000 RAI forms. There is another file named MDSC900b.pdf, that contains a summary of the revisions to the September 2000 update forms, compared to the 1/30/98 update version. Another download file named mdsimple.pdf includes the implementation and transition rules for the September 2000 Update RAI.

B. Supplemental Coding Instructions and Common Definitions.--These instructions and additional explanations supplement the instructions and definitions found within the sections of the MDS. Some MDS items are self-explanatory and therefore do not include definitions in this section. The numbering and lettering correspond to the elements of the MDS.

AA. IDENTIFICATION INFORMATION

1. Resident Name.--Legal name. Print using the following format: first name, middle initial, last name.

2. Gender.--Enter "1" for Male or "2" for Female.

3. Birthdate.--Use all boxes to record date. For months and days with only one digit, place a zero in the first box. For example, March 3, 1918 should be recorded **0 3 - 0 3 - 1 9 1 8**

4. Race/Ethnicity.--Enter the race or ethnic category the resident uses to identify him/herself.

5. Social Security and Medicare Numbers.--Record resident identifier numbers. Begin writing one number per box starting with the left most box.

6. Social Security Number: If no Social Security number for the resident is available (e.g., if the resident is a recent immigrant or a child), enter the standard "no information" code, "NA," or a circled dash.

7. Medicare Number (or comparable railroad insurance number).--Enter the resident's Medicare number. This number occasionally changes with marital status. In rare instances, the resident will have neither a Medicare number nor a Social Security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. In such cases, a "C" is placed in the left most Medicare Number box, and the remaining numbers are entered, one digit per box, beginning with the second box.

8. Facility Provider Numbers.--Record the facility identification numbers assigned to the nursing home by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; others will have Federal (Medicare) and State (Medicaid) identification numbers. Medicaid only facilities have a Federal as well as a State number. The Medicaid Federal number has a "letter" in the third box. The facility's Medicare and Medicaid numbers can be obtained from the facility's business office. Once you have these numbers, they apply to all residents of that facility. Begin writing in the left-hand box. Enter one digit per box.

9. Medicaid Number (if applicable).--This number is entered if the resident is a Medicaid recipient. Write one number per box, beginning in the left hand box. A "+" is entered in the left most box if the number is pending. If not applicable, enter "N" in the left most box.

10. Reasons for Assessment.--

11. Primary Reason for Assessment.--Document the key reason for completing the assessment, using the various categories of assessment types mandated by Federal regulation. Most of the types of listed assessments require completion of the MDS, review of triggered RAPs, and development or review of a comprehensive care plan within seven days of completing the RAI.

NOTE: Assessment type 5 (Quarterly Review Assessment) requires the assessor to complete only a limited number of MDS items.) Please note that it is possible to select a code from both A8a or AA8a (Primary Reason for Assessment) and A8b or AA8b (Special Medicare or State Codes).

12. Admission Assessment.--A comprehensive assessment using the MDS and RAPs required by day 14 of the resident's stay. Note, this code is used if the resident is being readmitted subsequent to a discharge where return was not anticipated.

13. Annual Assessment.--A comprehensive reassessment required within 12 months of the most recent full assessment. If a significant change is noted during the course of conducting an annual assessment, code "3" (significant change in status assessment) and DO NOT code as an annual assessment.

14. Significant Change in Status Assessment.--A comprehensive reassessment prompted by a "major change" that is not self-limited, that impacts on more than one area of the resident's clinical status, and that requires interdisciplinary review or revision of the care plan to ensure that appropriate care is given. When there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred.

15. Significant Correction of Prior Full Assessment.--A new comprehensive assessment (including the full MDS form, RAPs and care plan review) is completed when an uncorrected major error is discovered in a comprehensive assessment (MDS Item AA8a=1,2,3 or 4) that has already been accepted into the State MDS database, or in a prior comprehensive assessment that is no longer in the editing and revision process, having been completed 8 or more days ago (date at MDS item VB4), but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). Refer to detailed information under the heading "Significant Correction of Prior Full Assessment, (Code 4)", earlier in Part II of this State Operations Manual.

16. Quarterly Review Assessment.--The subset of MDS items specified on the State-specified Quarterly Review Form, which must be completed no less frequently than once every 3 months (i.e., between required full assessments). Additionally, Section AA must be completed as part of the quarterly review requirement.

17. None Of Above.--This code is used to indicate that the assessment has been completed to comply with Medicare or State-specific requirements (e.g., case-mix payment).

18. Significant Correction of Prior Quarterly Assessment.--A new quarterly assessment is completed when an uncorrected major error is discovered in a prior quarterly assessment (MDS Item AA8a=5 or 10), that has already been accepted into the State MDS database, or in a quarterly assessment that was completed 8 or more days ago (date at MDS item R2b) but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). Refer to detailed information under the heading "Significant Correction of Prior Quarterly Assessment, (Code 10)," earlier in Part II of this State Operations Manual.

19. Codes for Assessments Required for Medicare PPS or by the State.--It is possible to select a code from both MDS Item AA8a and AA8b (e.g., MDS Item AA8a coded "3" for a Significant Change in Status assessment, and MDS Item AA8b coded "3" for a Medicare 60-day assessment).

a. Medicare 5 day assessment (Code 1)

b. Medicare 30 day assessment (Code 2)

c. Medicare 60 day assessment (Code 3)

d. Medicare 90 day assessment (Code 4)

e. Medicare readmission/return assessment (Code 5)

f. Other State required assessment (Code 6).--

g. Medicare 14 day assessment (Code 7).--

h. Other Medicare required assessment (Code 8).--

20. Signatures of Persons Who Completed a Portion of the Accompanying Assessment or Tracking Form.--Upon implementation of the September, 2000 update of the RAI, version 2.0, individual staff members who complete any portion of an MDS assessment or tracking form (Sections AA, and A - V (including Sections T and U)) must sign and date at Items AA9 a - l, and indicate beside their signature the portion(s) they completed. Two or more staff members can complete Items within the same section of the MDS. In that case, the individual assessors must indicate the range of Items that they completed in that section. Signature at Items AA9 a - l certifies the accuracy of the portion of the assessment or tracking form completed by the individual assessor. States that have specified Section S for use by facilities in the State may opt to require signatures for Section S at Item AA9.

SECTION AB.--DEMOGRAPHIC INFORMATION

1. Date of Entry.--Normally, the MDS Face Sheet is completed once, when an individual first enters the facility. This is the date the person first became a resident in this facility. However, the face sheet is also required if the person is reentering this facility after a discharge where return had not previously been expected. It is not completed following temporary discharges to hospitals or after therapeutic leaves/ home visits. The date of entry is the date the resident entered the facility for care, regardless of how the facility chooses to "open" or "close" its medical records during the course of the stay.

2. Date the Stay Began.--The date the resident was most recently admitted to this facility.

3. Admitted From (At Entry).--The place from which the resident was admitted to the nursing home on the date given in item AB1.

4. Private Home or Apartment.--Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.

5. Home Health Services.--Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

6. Assisted Living.--A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

7. Other.--Includes psychiatric facilities, hospices, rehabilitation and chronic disease hospitals.

8. Lived Alone (Prior to Entry).--To document the resident's living arrangements prior to admission.

9. In Other Facility.--Any institutional/supportive setting, such as a nursing home, group home, sheltered care, board and care home.

10. Zip Code of Prior Primary Residence.--A primary residence includes a primary home or apartment, board and care home, assisted living, or group home. If the resident was admitted to the facility from another nursing home or institutional setting, the prior primary residence is the address of the resident's home prior to entering the other nursing home, etc.

11. Residential History 5 Years Prior to Entry.--Document the resident's previous experience living in institutional or group settings. Check all institutional or group settings in which the resident lived for the five years prior to the current date of entry (as entered in AB1.). Exclude limited stays for treatment or rehabilitation when the resident had a primary residence to return to. If the resident has not lived in any of these settings in the past five years, check "NONE OF ABOVE".

12. Prior Stay at This Nursing Home.--Resident's prior stay was terminated by discharge (without an expected return) to the community, another long-term care facility, or (in some cases) a hospitalization.

13. Stay in Other Nursing Home.--Prior stay in one or more nursing homes other than current facility.

14. Other Residential Facility.----Examples include board and care home, group home, and assisted living.

15. Mental Health/Psychiatric Setting.--Examples include mental health facility, psychiatric hospital, psychiatric ward of a general hospital, or psychiatric group home.

16. Mental Retardation/Developmental Disabilities (MR/DD) Setting.--Examples include mental retardation or developmental disabilities facility (including MR/DD institutions), intermediate care facilities for the mentally retarded (ICF/MRs), and group homes.

17. Lifetime Occupation.--Identify the resident's role or past role in life and to establish familiarity in how staff should address the resident. Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the facility. Begin printing in the left-most box. When two occupations are identified, place a slash (/) between each occupation.

18. Education (Highest Level Completed).--Record the highest level of education the resident attained.

19. Technical or Trade School.--Include schooling in which the resident received a non-degree certificate in any technical occupation or trade (e.g., carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).

20. Some College.--Includes completion of some college courses, junior (community) college, or associate's degree.

21. Bachelor's Degree.--Includes any undergraduate bachelor's level college degree.

22. Graduate Degree.--Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

23. Language - Primary Language.--The language the resident primarily speaks or understands.

24. Mental Health History.--To document a primary or secondary diagnosis of psychiatric illness or developmental disability. Review the resident's record only. There must be written documentation (i.e., verbal reports from the resident or resident's family are not sufficient). Resident has one of the following:

- o A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but
- o Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;
- o The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;
- o The treatment history indicates that the individual has experienced either: (a) psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

25. Conditions Related to MR/DD Status (Mental Retardation/Developmental Disabilities).--Document conditions associated with mental retardation or developmental disabilities.

26. Other Organic Condition Related to MR/DD.--Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macrencephaly, meningomyelocele, congenital hydrocephalus, etc.

27. Date Background Information Completed.--Enter date that background information sheet is originally completed. As new or clarifying information becomes available, the facility may record additional information on the form or enter data into the computerized record. This item should then reflect the date that new information is recorded or existing information is revised.

AC.--CUSTOMARY ROUTINE

Goes out 1+ days a week - Went outside for any reason (e.g., socialization, fresh air, clinic visit).

Use of tobacco products at least daily - Smoked any type of tobacco (e.g., cigarettes, cigars, pipe) at least once daily. This item also includes sniffing or chewing tobacco.

Distinct food preferences - This item is checked to indicate the presence of specific food preferences, with details recorded elsewhere in the clinical record (e.g., was a vegetarian; observed kosher dietary laws; avoided red meat for health reasons; hates hot dogs; allergic to wheat and avoids bread). Do not check this item for simple likes and dislikes.

Use of alcoholic beverage(s) at least weekly - Drank at least one alcoholic drink per week.

Wakens to toilet all or most nights - Awoke to use the toilet at least once during the night all or most of the time.

Has irregular bowel movement pattern - Refers to an unpredictable or variable pattern of bowel elimination, regardless of whether the resident prefers a different pattern.

Bathing in PM - Took shower or bath in the evening.

Daily contact with relatives/close friends - Includes visits and telephone calls. Does not include exchange of letters only.

Usually attends church, temple, synagogue (etc.) - Refers to interaction regardless of type (e.g., regular churchgoer, watched TV evangelist, involved in church or temple committees or groups).

Daily animal companion/presence - Refers to involvement with animals (e.g. house pet, seeing-eye dog, fed birds daily in yard or park).

Unknown - If the resident cannot provide any information, no family members are available, and the admission record does not contain relevant information, the last box in the category ("UNKNOWN"), is checked. All other boxes in Section AC are blank.

AD.--FACE SHEET SIGNATURES

a. Signature of RN Assessment Coordinator: The RN Assessment Coordinator who worked on the Background (Face Sheet) Information at Admission sections of the MDS enters his or her signature on the day this part of the MDS form is complete. Also, to the right of the name, the date the form was signed is entered.

b-g Signature of Others Who Completed Part of Background Assessment Sections AB and AC: Other staff who completed parts of the Background sections of the MDS enter their signatures, the sections they completed, and the day they completed their assigned sections. Signature at Items AD b-g certifies the accuracy of the portion of the Face Sheet completed by the individual assessor.

SECTION A.--IDENTIFICATION AND BACKGROUND INFORMATION

1. Resident Name: Legal name in record.

2. Room Number: Number of resident's room in facility.

3. Assessment Reference Date: To establish a common temporal reference point for all staff participating in the resident's assessment. Although staff members may work on completing a resident's MDS on different days, establishment of the assessment reference date ensures the commonality of the assessment period (i.e., "starting the clock" so that all assessment items refer to the resident's objective performance and health status during the same period of time).

a. Last Day of MDS Observation Period: This date refers to a specific end-point in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period, most frequently the seven day period ending on this date. The date sets the designated endpoint of the common observation period, and all MDS items refer back in time from this point. Some cover the seven days ending on this day, some 14 days prior, some 30 days prior, and so forth. The first coding task is to enter the observation reference date (i.e., the end point date of the observation period). For an admission assessment, this date can be any day up to the 14th day following admission (the last possible date for completing the admission assessment). For a follow-up assessment, select a common reference date within the period the assessment must be completed. This date is the endpoint to which all MDS items must refer.

b. Original (0) or Corrected Copy of Form (enter number of corrections): This item is inactive in the MDS system at the State.

4. Date of Reentry: To track the date of the resident's readmission to the facility following a temporary discharge. The date the resident was most recently readmitted to the facility after being temporarily discharged for hospital stay in last 90 days (or since last assessment or admission if less than 90 days).

5. Marital Status: Choose the answer that describes the current marital status of the resident.

6. Medical Record Number: This number is the unique identifier assigned by the facility for the resident.

7. Per diem - Room, board, nursing care, activities, and services included in the routine daily charge.

8. Current Payment Source(s) for Nursing Home Stay: To determine payment source(s) that cover the daily per diem and ancillary services for the resident's stay in the nursing facility over the last 30 days.

9. Ancillary: Services such as medications, equipment for treatments or supplies billed outside of the daily routine per diem charge.

10. Self (or family) Pays - Full: Includes full private pay by resident or family.

11. Self (or family) Pays - Co-Pay: The resident is responsible for a co-payment.

12. Private Insurance: The resident's private insurance company is covering daily charges.

13. Other: Examples include Commission for the Blind, Alzheimer's Association.

14. Reasons for Assessment:

A. Primary Reason for Assessment.--Document the key reason for completing the assessment, using the various categories of assessment types mandated by Federal regulation. Most of the types of listed assessments require completion of the MDS, review of triggered RAPs, and development or review of a comprehensive care plan within seven days of completing the RAI. [Note -- assessment type 5 (quarterly review assessment) requires the assessor to complete only a limited number of MDS items.] Note that it is possible to select a code from both MDS Item AA8a (Primary Reason for Assessment) and MDS Item AA8b (Special Medicare or State Codes).

1. Admission Assessment.--A comprehensive assessment using the MDS and RAPs required by day 14 of the resident's stay. Note, this code is used if the resident is being readmitted subsequent to a discharge where return was not anticipated.

2. Annual Assessment.--A comprehensive reassessment required within 12 months of the most recent full assessment. If a significant change is noted during the course of conducting an annual assessment, code "3" (significant change in status assessment) and DO NOT code as an annual assessment.

3. Significant Change in Status Assessment.--A comprehensive reassessment prompted by a "major change" that is not self-limited, that impacts on more than one area of the resident's clinical status, and that requires interdisciplinary review or revision of the care plan to ensure that appropriate care is given. When there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred.

4. Significant Correction of Prior Full Assessment.--A new comprehensive assessment (including the full MDS form, RAPs and care plan review) is completed when an uncorrected major error is discovered in a prior comprehensive assessment (MDS Item AA8a=1,2,3 or 4) that has already been accepted into the State MDS database, or in a comprehensive assessment that is no longer in the editing and revision process, having been completed 8 or more days ago (date at MDS item VB4), but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). Refer to detailed information under the heading "Significant Correction of Prior Full Assessment, (Code 4)," earlier in Part II of this State Operations Manual.

5. Quarterly Review Assessment.--The subset of MDS items specified on the State-specified Quarterly Review form, which must be completed no less frequently than once every 3 months (i.e., between required full assessments). Additionally, Section AA must be completed as part of the quarterly review requirement.

6. Discharged - Return Not Anticipated.--This code is used whenever a resident is permanently discharged from a nursing facility. This is a means of "closing" the record of any resident at the point of discharge from the facility (without an anticipated return).

7. Discharged - Return Anticipated.--This code is used when a resident is temporarily discharged to a hospital or other therapeutic setting

8. Discharged Prior to Completing Initial Assessment.--This code is used when the resident is discharged during the first 14 days of residency and the comprehensive, Initial Admission assessment (MDS Item AA8a=1), including the RAPs, has not been completed. A subset of information is entered for all residents regardless of length of stay in the long-term care facility.

9. Reentry.--A subset of MDS items must be completed for residents "reentering" the facility after a temporary absence (other than a therapeutic leave) in order to reenter the resident into the State database.

10. Significant Correction of Prior Quarterly Assessment.-- A new quarterly assessment is completed when an uncorrected major error is discovered in a prior quarterly assessment (MDS Item AA8a=5 or 10), that has already been accepted into the State MDS database, or in a quarterly assessment that was completed 8 or more days ago (date at MDS item R2b) but has not yet been accepted into the MDS database at the State (this could include an assessment containing a major error that has not yet been transmitted, or that has been submitted and rejected). Refer to detailed information under the heading "Significant Correction of Prior Quarterly Assessment (Code 10)," earlier in Part II of this State Operations Manual.

11. None Of Above.--This code is used for Section A to indicate that the assessment has been completed to comply with Medicare or State-specific requirements (e.g., case-mix payment).

B. MDS item codes for assessments required for Medicare PPS or the State.--

Medicare 5 day assessment, (Code 1)

Medicare 30 day assessment, (Code 2)

Medicare 60 day assessment, (Code 3)

Medicare 90 day assessment, (Code 4)

Readmission/return assessment, (Code 5)

Other State required assessment, (Code 6).

Medicare 14 day assessment, (Code 7)

Other Medicare required assessment, (Code 8)

Note that it is possible to select a code from both MDS Items A8a and A8b (e.g., Item A8a coded "3" for a Significant Change in Status assessment, and MDS Item A8b coded "3" for a Medicare 60-day assessment).

1. Responsibility/Legal Guardian.--Record who has responsibility for participating in decisions about the resident's health care, treatment, financial affairs, and legal affairs. Depending on the resident's condition, multiple options may apply. Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your State and to the facility's legal counsel, as appropriate, for additional clarification. Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

SECTION R.--SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT

2. Signatures ~~of Persons~~ Coordinating the Assessment.--The RN Assessment Coordinator signs and dates at Items R2a-b, certifying completion of all portions of the MDS Sections A-R included in the MDS record. The RN Assessment Coordinator must not sign and attest to completion of the assessment until after all other assessors have completed their portions of the MDS, and signed, certifying completion and accuracy. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

THE MDS CORRECTION REQUEST FORM

The federal requirements for use of the MDS Correction Request Form, as part of MDS Correction Policy, are specified in Part IV of Appendix R. The Correction Request Form includes two sections; the Prior Record Section (Prior AA), and the Correction Attestation Section (AT).

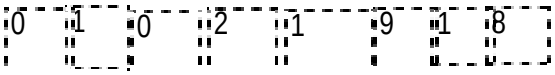
PRIOR_AA. PRIOR RECORD SECTION

The Prior Record Section is used to locate the erroneous assessment or tracking form record in the State database. Obtain the information for this section from the previously submitted, erroneous assessment or tracking form. Record the information ***exactly as submitted and accepted into the State database***, **even if it was wrong**. For example: The MDS assessment was submitted and accepted for Joan L. Smith. When the encoder "key entered" the assessment, he typed "John" by mistake. To correct this error, the facility should complete a Correction Request Form and a corrected assessment form. When completing the Resident's Name Item in the Prior Record Section of the Correction Request Form, "John" should be entered. This will permit the State system to locate the previously submitted assessment that is being corrected. If the correct name "Joan" were entered, the State system would not be able to locate the prior assessment.

Prior_AA1. Resident Name: Enter the resident's name exactly as submitted in MDS item AA1on the prior, erroneous record.

Prior_AA2. Gender: Enter the gender code exactly as submitted in MDS item AA2 on the prior, erroneous record.

Prior_AA3. Birthdate: Fill in the boxes with the appropriate date exactly as submitted in MDS item AA3 on the prior, erroneous record. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example, January 2, 1918, should be entered as:

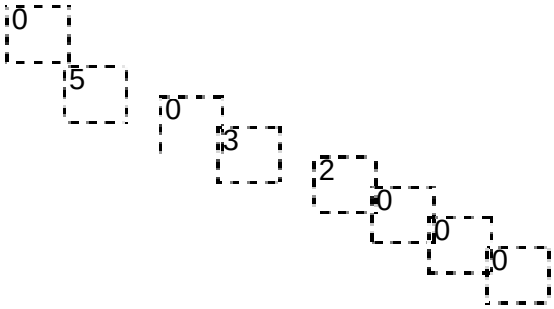


Prior_AA5a. Social Security Number: Fill in the boxes with the resident's social security number exactly as submitted in MDS item AA3 on the prior, erroneous record. Begin writing one number per box starting with the left most box. Recheck the number to be sure you have written the digits correctly.

Prior_AA8a. Primary Reason for Assessment: Enter the two digit code corresponding to the primary reason for assessment exactly as submitted in MDS item AA8a on the prior, erroneous record.

Prior_AA8b. Codes for Assessments Required for Medicare PPS or the State: Enter the one digit code corresponding to the special Medicare PPS or State reason for assessment exactly as submitted in MDS item AA8b on the prior, erroneous record. If this item was blank on the prior, erroneous assessment, then it should be blank on this item on the Correction Request.

PRIOR_DATE. (Complete one *ONLY*) -- This section is used to document the reference date for the prior record. If the prior, erroneous record is an assessment, complete the PRIOR_A3a Assessment Reference Date only. If the prior record is a discharge tracking form, complete the PRIOR_R4 Discharge Date only. If the prior record is a reentry tracking form, complete the PRIOR_A4a date of reentry only. Fill in the boxes with the appropriate date exactly as submitted on the prior, erroneous assessment or tracking form record. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example, May 3, 2000 should be entered as:



Prior_A3a. Assessment Reference Date: If the prior, erroneous record was an assessment (PRIOR_AA8a equals 01, 02, 03, 04, 05, 10, or 00), enter the Assessment Reference Date exactly as submitted in the prior MDS item A3a. Leave blank if the prior record was a discharge or reentry (PRIOR_AA8a is equal to 06, 07, 08, or 09).

Prior_R4. Discharge Date: If the prior, erroneous record was a Discharge Tracking Form (Prior_AA8a equals 06, 07, or 08), enter the Discharge Date exactly as submitted in the prior MDS item R4. Leave blank if the prior record was an assessment or reentry (PRIOR_AA8a equals 01, 02, 03, 04, 05, 09, 10, or 00).

Prior_A4a. Date of Reentry: If the prior, erroneous record was a Reentry Tracking form (PRIOR_A4a equals 09), enter the date of reentry exactly as submitted in the prior MDS item A4a. Leave blank if the prior record was an assessment or discharge (PRIOR_AA8a equals 01, 02, 03, 04, 05, 06, 07, 08, 10, or 00).

AT. CORRECTION ATTESTATION SECTION

The Correction Attestation Section is used to collect attestation information; and to describe the reason for the correction request and whether the request is to modify or to inactivate an MDS assessment or tracking form record that has been previously submitted and accepted by the State database.

AT1. Attestation Sequence Number: Item AT1 identifies the total number of correction requests following the original assessment or tracking record, including the present request. This item is used to track successive correction requests. Note that prior to implementation of the Correction Request Form, MDS Item A3b was intended for this purpose. With the inclusion of Item AT1 on the Correction Request Form, MDS Item A3b will not be needed and has been made inactive in the standard system at the State. For the first correction request for an MDS record, code a value of 01 (zero-one); for the second correction request, code a value of 02 (zero-two); etc. With each succeeding request, AT1 is incremented by one. For values between one and nine, a leading zero should be used in the first box.

AT2. Action Requested: This Item is used to identify whether the correction request is being submitted to modify or to inactivate a prior, erroneous assessment or tracking form. Enter "1" if the action requested is to MODIFY an assessment or tracking form. Enter "2" if the requested action is to INACTIVATE an assessment or tracking form.

AT3. Reasons for Modification: This Item is used to identify the reason(s) for the error(s) that require modification of the prior, erroneous assessment or tracking form record that has been previously submitted and accepted by the State database. If the Action Requested at Item AT2 was "1" (Modify), then check all that apply at Item AT3. Leave all of AT3 blank and proceed to Item AT4, if Item AT2 was coded "2" (Inactivate). Definitions and examples of Reasons for Modification are as follows:

a. Transcription Error.--Includes any error made recording MDS assessment or tracking form information from other sources. An example is transposing the digits for the patient's weight (e.g., recording "191" rather than the correct weight of "119" that appears in the medical record).

b. Data Entry Error.--Includes any error made while encoding MDS assessment or tracking form information into the facility's computer system. An example is a "key punching" error where the response to a minutes of therapy item (P1b) is incorrectly encoded as "3000" minutes rather than the correct number of "0030" minutes recorded on the MDS form.

c. Software Product Error.--Includes any error created by the encoding software, such as, "storing" an item with the wrong format (e.g., misplacing the decimal point in an ICD-9 code in item I3) or "storing" an item in the wrong position in an electronic MDS record.

d. Item Coding Error.--Includes any error made coding an MDS item, such as choosing an incorrect code for an ADL self-performance item in G1 (e.g., choosing a code of "4" in G1aA for a resident who requires limited assistance and should be coded as "2"). Item coding errors may result when an assessor makes an incorrect judgement or misunderstands the RAI coding instructions.

e. Other Error.--Includes any other reason for error that causes a prior assessment or tracking form record to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to final completion of editing and review. Facility staff should describe the "other error" in the space provided on the form.

AT4. Reasons for Inactivation: This item is used to identify the reason(s) requiring inactivation of an invalid assessment or tracking form record that has been previously submitted and accepted into the MDS database at the State. If the Action Requested at Item AT2 was "2" (Inactivate), then check all that apply at Item AT4. Leave all of AT4 blank and complete Item AT3, if Item AT2 was coded "1" (Modify). Definitions and examples of Reasons for Inactivation are as follows:

a. Test Record Submitted as a Production Record.--An example is a fictitious assessment or tracking form record which was fabricated to test a software product and then inadvertently submitted to the State as a production record.

b. Event Did Not Occur.--Includes submission of an assessment or tracking form record describing an event that did not occur. The event did not occur if *any* of the following conditions apply:

1) The record submitted does not correspond to an actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was *no event*.

2) The record submitted identifies the *wrong resident*. For example, a discharge tracking form was completed and submitted for the wrong person.

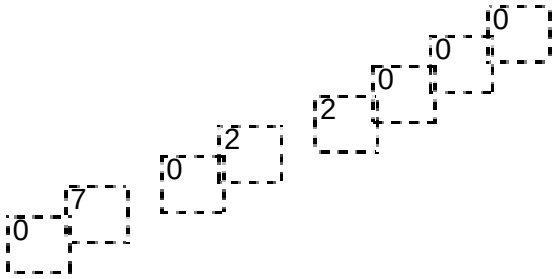
3) The record submitted identifies the *wrong reasons for assessment*. For example, a Reentry Tracking Form was submitted when the resident was discharged.

c. Inadvertent Submission of Inappropriate Record.--An example would be submission of a *non-required* assessment performed for an "in-house" quality improvement or quality assurance program being conducted by the facility.

d. Other Reason Requiring Inactivation.--Includes any other reason for error that causes a prior assessment or tracking form record to require inactivation under the Correction Policy. Facility staff should describe the "other error" in the space provided on the form.

AT5. Name: Enter the name of the RN Assessment Coordinator attesting to the completion of the MDS Correction Request Form, and corrected information. Begin with the first name (at Item AT5a), followed by the last name (at Item AT5b), and then their title (at Item AT5c). In addition, when the form is complete, the RN Assessment Coordinator must sign a hard copy of the Correction Request Form, certifying completion.

AT6. Date: Enter the date the facility staff certified the completion and accuracy. Do not leave any boxes blank. For a one digit month or day, place a zero in the first box. For example, July 2, 2000, should be entered as:



AT7 Attestation of Accuracy and Signatures of Persons Who Correct a Portion of Assessment or Tracking Information: Individuals who correct any portion of an MDS record or complete any portion of the MDS Correction Request Form must sign and date a hard copy of the MDS Correction Request form, indicating their title beside their signature. Signature certifies the completion and accuracy of information they corrected, and the portion(s) of the MDS Correction Request Form they completed.

PART III - RESIDENT ASSESSMENT PROTOCOLS

Part of the utilization guidelines, the resident assessment protocols (RAPs) are problem-oriented frameworks for additional assessment and problem identification that form the final linkage to decisions about care planning. There are 18 RAPs in version 2.0 of the RAI. The RAPs in HCFA's RAI cover approximately 90 - 95% of the areas that are addressed in a typical nursing home resident's care plan. Each RAP has 4 parts: (1) the Statement of Problem, (2) Triggers, (3) Guidelines, and (4) the RAP key. Upon completing the triggered RAPs for a resident, staff will have:

- o Identified the unique problems the resident has that may adversely affect his/her highest practicable physical, mental, and psychosocial functioning;

- o Identified factors that place the resident's highest practicable physical, mental, and psychosocial functioning at risk;

- o Considered whether the identified potential problems could be prevented or reversed, or risk factors minimized, and evaluated the extent to which the resident is able to attain a higher level of well-being and functional independence; and

- o Evaluated ongoing care practices for that resident by, for example, considering alternative therapies and the need for medical consultation, or consultation(s) by other health professionals such as occupational or physical therapists.

The RAPs must be completed whenever a full assessment is required, unless the facility uses the full MDS as its quarterly review (i.e., the facility must complete the RAPs upon admission, significant change, and annual reassessment).

To use RAPs, long term care facility staff shall follow these steps:

- o Review the completed MDS to identify triggered RAPs. This may be performed automatically by software in automated systems or manually by using the RAP Trigger Legend.

- o In the left-hand column of the RAP Summary form next to the RAPs, "Check if triggered," place a checkmark next to each triggered RAP.

- o For each triggered RAP, review the RAP Guidelines. This review process assists the assessor to collect and analyze additional relevant information regarding the triggered condition. The Guidelines also help the assessor examine causal factors that affect the resident's condition and offer suggestions regarding how factors contributing to the resident's problems can be eliminated or minimized.

- o Describe the following key information:

  - -- Nature of the condition (may include presence or lack of objective data or subjective complaints);

  - -- Complications and risk factors, which include the presence of causal factors, that may be identified by the Guidelines;

  - -- Factors that must be considered in developing individualized care plans;

-- The need for referrals to appropriate health professionals; and

-- The reasons for deciding to proceed or not to proceed with care planning for triggered problems.

It is not necessary to document findings for each issue or question in the Guidelines. Documentation for each triggered RAP should address the nature of the problem(s) as evidenced by objective findings and subjective complaints of the resident. If the triggered RAP is not a problem for the resident, documentation should include what clinical factors from the RAP review process support that decision.

o In the "Location of Information" column of the RAP Summary form, indicate where the assessment information is documented. Indicating that the problem is included in the care plan is not enough. If the facility references the care plan as the location of information, all information listed above would have to be documented in the care plan.

o Complete the "Care Planning Decision" column last. This indicates whether the RAP area was care planned. It must be completed within seven days of the completion of the comprehensive assessment (i.e., within the regulatory timeframe for the completion of the care plan).

The RN coordinator must sign the MDS and the RAP Summary form to signify completion of the assessment. There is no Federal requirement that each staff member completing a RAP sign and date the RAP Summary form to certify its accuracy. They may wish to indicate which RAP(s) they completed, list any credentials, and the date it was completed. If they desire to do so, other staff members may sign the form wherever there is room to do so in a legible manner.

The staff person entering the care planning decision information must also sign and date the RAP Summary form. The facility has 7 days after completing the assessment to complete the care plan. The date for entering of the care plan information may be up to 7 days after the RAPs are completed (i.e., the date on which the RN Coordinator signed to indicate completion of the RAP assessment process).

HCFA will develop additional RAPs in the future. States may also develop additional RAPs and request approval to include them in the State specified RAI.

This Page Reserved for the
"Resident Assessment Protocol"-- Pages R-57 - R-150
THIS SECTION IS IN PRINTED FORM ONLY

PART IV. LONG TERM CARE MINIMUM DATA SET (MDS) AUTOMATION REQUIREMENTS

The Final Rule, HCFA-2180-F, "Medicare and Medicaid; Resident Assessment in Long Term Care Facilities", sets forth new conditions of participation that, as of June 22, 1998 require all Medicare or Medicaid-certified facilities, as defined in CFR 483.5, to establish a database of resident assessment information for every resident in the facility, regardless of their payor source, and then electronically send that information to the State.

A. Definitions.--

Encoding means entering MDS information into a computer.

Passing standard edits means that the responses to MDS and RAP summary (where applicable) items are encoded in accordance with HCFA specified standards. The Standard MDS system at the State will reject (not accept into the State database) an MDS record (assessment, Discharge or Reentry Tracking Form or correction Request Form) that contains any out of range values (e.g., item coded 5 when valid responses are 1, 2, 3 or 4); that contains selected inconsistencies between item responses (e.g., skip pattern ignored); that omits critical information (e.g., information that identifies the facility, the resident, or the type of record); that contains impossible date relationships (e.g., admission earlier than birthdate); that involve miscalculations for selected items (e.g., a miscalculated RAP trigger); or that violates selected formatting requirements (e.g., a misplaced decimal in an ICD-9 diagnosis code); or that is a duplicate of a record that already exists in the State MDS database. The fatal record edit for out of range values applies to most, but not all MDS Items. Other edits will result in non-fatal record errors, (the record will not be rejected), for example: errors involving timing between assessments and assessments out of sequence; errors involving certain formatting requirements, such as text entries that are not upper case; and certain calculated items, such as RUGs. In accordance with the final rule, facilities are responsible to edit the encoded MDS data to ensure that it meets HCFA's standard edit specifications.

Within the time period specified for editing and revision as detailed below, and in Exhibit 263, "Maximum Time Frames for MDS Completion, Data Entry, Editing and Transmission", the facility must edit MDS information using standard HCFA-specified edits, revise the information to conform to the edits and to be accurate, and be capable of transmitting that data to the State system. After editing and revision, MDS information and RAP summary information (if applicable) must always accurately reflect the resident's status as of the original Assessment Reference Date for an assessment or the event date for a discharge or reentry.

The time frames for editing and revision of MDS records are within 7 days of completing a comprehensive assessment (the date at MDS item VB4), within 7 days of completing an assessment that is not comprehensive (the date at MDS item R2b), within 7 days of a discharge event (the date at MDS item R4), within 7 days of a reentry event (the date at MDS item A4a), or within 7 days of completing a Correction Request Form (the date at MDS item AT6).

After the end of the editing and revision process (7 days after final completion of an assessment or 7 days after the event for a discharge or reentry), MDS records found to be in error should be corrected using the correction policy for MDS Records below. The MDS vendor software used at standard edit specifications are published on our website at www.hcfa.gov/medicaid/mds20, under "MDS Software and Data Specifications" and then under the MDS Data Specifications, "Version 1.10 Files". We encourage facilities to use software that has a programmed capability to automatically edit MDS records according to HCFA's edit specifications.

Capable of transmitting means that the facility has encoded and edited according to HCFA specifications and the record is ready for electronic transmission.

Electronic transmission refers to electronically sending encoded MDS information, from the facility to the State database, using a modem and communications software.

Monthly means no more than 31 days.

B. Required MDS Records.--The requirement to encode and electronically transmit MDS data from the facility to the State MDS database applies to all Federally required resident assessments, including MDS forms (Sections AA through R, and V - the RAP Summary Form), Quarterly Review Forms, and Discharge and Reentry Tracking Forms. Facilities are responsible to electronically transmit to the State all required assessments as they become due (regardless of assessment type) as well as any Discharge and Reentry Tracking Forms. Version 2.0 Face Sheet information must also be transmitted. On an ongoing basis, Background (Face Sheet) information is completed and transmitted with every admission assessment. There is an additional Background (Face Sheet) requirement when the facility first begins transmissions to the State. For residents already in the facility when transmissions to the State begin, background (Face Sheet) information must also be included and transmitted with the first MDS assessment of any type (not including Discharge or Reentry Tracking Forms). States may have additional specifications regarding completion and submission of assessments. There is not a Federal requirement for transmission of historic assessments (e.g., completed prior to the effective date of requirement to encode and transmit data.

The MDS system at the State checks records against HCFA data specifications and against prior records submitted, and makes a determination regarding whether the sequence of assessment types received for each resident is valid. For example, following a comprehensive assessment, the system would expect a series of three Quarterly assessments, no later than 92 days apart, followed by an annual assessment, no later than 366 days from the completion date of the last comprehensive assessment (based on the date at MDS item VB4), unless the system is notified otherwise, (e.g., via receipt of a Significant Change Assessment or a Discharge Tracking Form).

C. Correction Policy for MDS Records.--On May 22, 2000, HCFA implemented, by incorporation into the MDS standard system, two separate system enhancements designed to improve the accuracy of information in the State MDS databases. The first system enhancement involves the refinement of the MDS record editing process in the standard MDS system to include stricter enforcement of existing edits. The second enhancement involves a new mechanism to enable facilities to submit electronic requests to correct any type of errors in MDS records that reside in the State database. This new correction mechanism involves the use of an MDS Correction Request Form to allow either modification or inactivation of a record that has actually been accepted into the State database. As a direct result of the enhanced editing and record rejection process, very few records with errors will be accepted by the State MDS system, and the need for corrections should be rare.

Prior to implementation of Correction Policy, facilities had no easy mechanism of making corrections to erroneous data in their MDS records in the State database. However, State Agency staff had the capability to change data in facility MDS records at the State, at the facility's request. The new mechanism enabling facilities to make electronic corrections to their MDS records in the State MDS database eliminates the need for States to make corrections to facilities' records. This new, facility-driven correction mechanism (incorporated into the standard MDS system May 22, 2000), along with the formal attestation requirements (implemented September 1, 2000, along with the accompanying) make facilities solely accountable for any changes to their MDS records in the State database. Therefore, upon the introduction of Correction Policy and formal attestation requirements, States' ability to change information in facility records in the State database will be phased-out. States may not accept or act on requests for manual corrections from facilities that are dated after May 21, 2000; and States must clear any back-log of requests for manual corrections by September 1, 2000.

The Correction Policy Flowchart (Exhibit 262) depicts the sequential decision-making and action steps for facility staff to follow when an error is detected in an MDS assessment, Discharge Tracking form, or Reentry Tracking form. In this flowchart, the diamond shapes represent decisions that facility staff must make about the type of error(s), and the solid rectangles represent the corrective action a facility should take. There is a code number to the right of each solid rectangle to allow reference to that corrective action. For example, the corrective action "Send Inact. [Inactivation] Request to State" is labeled as corrective action "***1***". The flowchart can be thought of as a "decision tree", and in that sense, it is a useful tool for determining appropriate corrective actions. There are nine different paths through the decision tree, each path being associated with a scenario involving specific facility actions. Each path involves one or two corrective actions. These paths or scenarios are labeled with the code numbers of the actions involved. For example, the left most path (involving action "1" only) is referred to as "Scenario 1". Similarly, the right most path (involving both actions "4" and "5") is referred to as "Scenario 4/5".

1. Errors in MDS Records in the State MDS Database.--When an error is detected in an MDS record that has already been submitted and accepted into the MDS database at the State, facility staff should submit a request to correct the error(s) to the State, using an electronic MDS record which includes Correction Request Form information. The Correction Request Form information is used primarily to locate the erroneous record in the State database. It is also used to indicate whether the record in error requires Inactivation or Modification.

For a modification, both the information on the Correction Request Form and the corrected assessment or tracking form is encoded into a single, electronic submission record according to HCFA's standard MDS Data Specifications. This submission record includes data from the entire, corrected MDS assessment or tracking form, not just the corrected values for the items that were in error.

For an inactivation, the facility encodes the information from the Correction Request Form into an electronic submission record according to HCFA's standard MDS Data Specifications. In this case, the submission record contains the correction request information only, and assessment or tracking form information must be blank. Exhibit 272, "Overview of MDS Submission Record", depicts the required contents of a submission record, depending on whether the record is an original record, an inactivation request, or a modification request.

a. Inactivating an Invalid MDS Record in the State MDS Database, Scenario 1.--A facility should inactivate a record in the State database when the record is invalid and should not actually have been submitted. Even if an invalid record in the State database contains other errors, this invalid record should not be modified. Any invalid record should be inactivated. A record is considered to be invalid in any of the following cases:

1) It was a test record inadvertently submitted as a production record.

2) The event did not occur.

a) The record submitted does not correspond to any actual event. For example, a discharge tracking form was submitted for a resident, but there was no actual discharge. There was no event.

b) The record submitted identifies the wrong resident. For example, a discharge tracking form was completed and submitted for the wrong person.

c) The record submitted identifies the wrong reasons for assessment. For example, a Reentry Tracking Form was submitted when the resident was discharged.

3) Inadvertent submission of an inappropriate, non-required record.

a) Modifying a Valid MDS Record in the State MDS Database.--A facility performs a Data Correction to modify a valid record that resides in the State database when the record is known to have data errors. Because a record is valid, it does not mean that it is error-free. One or more MDS Items in a valid record may have data errors. A record is considered to be valid if it meets all of the following conditions:

- It is not a test record.
- The record corresponds to an actual event.
- The record identifies the correct resident.
- The record identifies the correct reasons for assessment.
- The record is required to be submitted.

2. Tracking Form Error, Scenario 2.--For a tracking form error, the facility corrects a copy of the tracking form and also completes a Correction Request Form, indicating that the required action is modification. The facility transmits a submission record to the State.

3. Assessment Error: Determine Whether the Error Was Major and Uncorrected.--Modification of an MDS assessment does not necessarily insure a current, accurate view of the resident's overall clinical status, or the appropriateness of the current care plan. Even though an assessment is modified, a new Significant Correction or Significant Change assessment and an update to the care plan may also be required. A data correction cannot simply substitute for a "Significant Correction of Prior" or a "Significant Change in Status" assessment. To do so would jeopardize the clinical integrity of the MDS process.

One complication that can occur with the modification of a comprehensive assessment record is the possibility that RAPs will trigger differently (newly trigger, untrigger, or trigger for different reasons) as a result of changes made to the assessment record. Facilities should establish a procedure whereby RAPs are recalculated and submitted anytime corrections involving RAP trigger items are made to a comprehensive assessment record.

Whenever it is determined that an MDS assessment record in the State database requires modification, facility staff must make an additional determination regarding whether the error was major and was not corrected with a subsequent assessment. An error is major if the resident's

overall clinical status has been miscoded on the MDS assessment or if the care plan derived from the assessment does not suit the resident's needs. A major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's overall clinical status and an appropriate care plan.

a. When the Assessment Error Was Not a Major Error or Has Been Corrected, Scenario 2/6.--If an assessment error was not major or if a major error has been corrected by a subsequent assessment, then the facility need only make a data correction and submit a correction request to modify the erroneous record in the database. There is no need for a new assessment to be performed.

b. When a Major Assessment Error Has Not Been Corrected on a Subsequent Assessment.--If the assessment error is major, and it has not been corrected on a subsequent assessment, the facility should complete and transmit both the correction request to modify the erroneous record in the database, and a new significant change or significant correction assessment, whichever is appropriate. Significant change in status assessments and significant correction of prior assessments are entirely new assessments of the resident, based upon a new Assessment Reference Date (MDS Item A3a).

4. No Significant Change in Status Has Occurred, Scenario 2/7.--The facility must also determine whether the resident's status has actually changed since the erroneous assessment was completed. If the resident has not experienced a significant change in status, in addition to submitting the modification request, the facility must also perform and transmit a significant correction of prior full or quarterly assessment, whichever is appropriate. If the assessment in error was a comprehensive assessment, requiring RAPs, Triggers and care plan review, (the primary reason for assessment in MDS Item AA8a indicated the assessment as an admission, annual, significant change in status, significant correction of prior full), then a new significant correction of a prior full assessment must be completed, including RAPs, Triggers and care plan review. If the assessment in error was not a comprehensive assessment (the primary reason for assessment in MDS Item AA8a indicated the assessment as a quarterly or significant correction of prior quarterly assessment), then a new significant correction of a prior quarterly assessment must be performed and submitted.

5. Significant Change in Status Has Occurred, Scenario 2/8.-If the assessment error is major, and it has not been corrected on a subsequent assessment, and the resident has experienced a significant change in status since the Assessment Reference Date (MDS Item A3a) of the original, erroneous assessment, then in addition to submitting a request to modify the erroneous assessment, the facility must also perform and transmit a significant change in status assessment. In any instance in which a resident experiences a significant change in status, regardless of whether there was also an error on the previous assessment, a significant change in status assessment must be completed by the end of the 14th calendar day following the determination that a significant change occurred.

6. Errors in MDS Records That Are Not In the State MDS Database.--Records that are not in the State MDS database include those that have not been data entered, have not been transmitted, or have been transmitted and rejected. The automated mechanism for correcting records in the MDS database at the State and the use of the MDS Correction Request Form is not appropriate for records that have not been accepted. When an error occurs in an MDS record (assessment, or discharge or reentry tracking form) that has not been accepted into the State database, facility staff should determine whether the record should be excluded from submission or corrected and then submitted.

a. Excluding an Invalid MDS Record Not in the State MDS Database, Scenario 3.--The facility should exclude (not submit) an invalid record that should not actually have been submitted. A record is considered to be invalid in any of the following cases:

1) It was a test record inadvertently created as a production record.

2) The event did not occur.

a) The record created does not correspond to any actual event. For example, a discharge tracking form was created for a resident, but there was no actual discharge. There was no event.

b) The record created identifies the wrong resident. For example, a discharge tracking form was completed for the wrong person.

c) The record created identifies the wrong reasons for assessment. For example, a Reentry Tracking Form was created when the resident was discharged.

b. Correcting a Valid MDS Record Not in the State MDS Database.--A facility should perform an in-house correction when a valid record has not been accepted and is known to have data errors. A record is considered to be valid if it meets all of the following conditions:

- It is not a test record.
- The record corresponds to an actual event.
- The record identifies the correct resident.
- The record identifies the correct reasons for assessment.
- The record is required to be submitted

Since the erroneous record does not reside in the MDS database at the State, the electronic and paper records are corrected in the facility and use of the MDS Correction Request Form does not apply. Paper records should be corrected using standard medical records procedures. That is, the person responsible for the accuracy of the information enters the correct response, draws a single line through the previous response without obliterating it, and initials and dates the corrected entry.

1) Tracking Form Error, Scenario 4.--Whenever a valid Discharge or Reentry Tracking Form record is found to be in error but has not been accepted by the standard MDS system at the State, then the facility need only correct that record in-house and submit it.

2) Assessment Error: Determine Whether it Has Been Eight or More Days since Assessment Completion.--Whenever a valid MDS assessment record is found to be in error but has not been accepted by the standard MDS system at the State, the facility should correct and submit that assessment record. The facility should take additional action if the error was detected outside of the standard MDS editing time frame of seven days after the final assessment completion date. Final assessment completion is defined as the date the care planning decision process was completed (MDS Item VB4) for comprehensive assessments, or the date the RN Coordinator certified that the MDS was complete (MDS Item R2b) for non-comprehensive assessments. In accordance with the clinical process, the facility must use the information contained in the Resident Assessment Instrument as the basis for the resident's care plan, and the care plan must be developed, or revised if appropriate, within seven days after final completion of an assessment.

a) Assessment Error Detected During Seven Day Editing Period, Scenario 4/5.--If an assessment error is detected within the seven day editing time frame, the facility should correct the record and ensure its accuracy relative to the resident's status as of the event date (MDS Item A3a for assessments); edit the record using HCFA specified edits; and then submit the corrected record to the State. It may also be appropriate to update the resident's care plan, based on

the revised assessment record. When the erroneous record does not reside in the MDS database at the State, the electronic and paper records are corrected in-house, and the MDS Correction Request Form should not be used.

b) Assessment Error Detected Eight or More Days Since Completion.--If the error is detected eight or more days after the assessment was completed (i.e., after the editing phase), the assessment record should be corrected and submitted. Additional action may also be required, depending on whether the error was major. Whenever an MDS assessment record that resides only in the facility is found to be in error, and the error was detected eight or more days after the assessment final completion date (MDS Item VB4 for comprehensive assessments or Item R2b for other assessments), the facility must correct and submit that record and update the care plan if necessary. In addition, the facility must determine whether the assessment error was major and not corrected with a subsequent assessment. An error is major if the resident's overall clinical status has been miscoded on the assessment or the care plan derived from the assessment does not suit the resident's needs. A major error is uncorrected when there is no subsequent assessment that has resulted in an accurate view of the resident's status and an appropriate care plan.

3) When the Assessment Error Was Not a Major Error or Has Been Corrected, Scenario 4/6.--If the assessment error was not major or if a major error has been corrected by a subsequent assessment, then the facility need only correct and submit the record. There is no need for a new assessment to be performed as a clinical correction step.

4) When a Major Assessment Error Has Not Been Corrected on a Subsequent Assessment.--If the error is major, and it has not been corrected on a subsequent assessment, the facility should correct and transmit the assessment to the State. In addition, facility staff must also determine whether the resident's status has actually changed since the erroneous assessment was completed, and if it has, whether this was a significant change in status. The facility must then perform and transmit a new significant change or significant correction assessment, whichever is appropriate.

a) No Significant Change in Status Has Occurred, Scenario 4/7.--If the error is major, and it has not been corrected on a subsequent assessment, and the resident has not experienced a significant change in status, then in addition to transmitting the corrected assessment to the MDS database at the State, the facility must also perform and transmit a significant correction of prior assessment. If the assessment in error was a comprehensive assessment, requiring RAPs, Triggers and care plan review, (the primary reason for assessment in MDS Item AA8a indicated the assessment as an admission, annual, significant change in status, significant correction of prior full), then a new significant correction of a prior full assessment must be completed, including RAPs, Triggers and care plan review. If the assessment in error was not a comprehensive assessment (the primary reason for assessment in MDS Item AA8a indicated the assessment as a quarterly or significant correction of prior quarterly assessment), then a new significant correction of a prior quarterly assessment must be performed and submitted.

b) A Significant Change in Status Has Occurred, Scenario 4/8.--If the assessment error is major, and it has not been corrected on a subsequent assessment, and the resident has experienced a significant change in status since the assessment reference date (MDS Item A3a) of the original, erroneous assessment, then in addition to transmitting the corrected assessment to the MDS database at the State, the facility must also perform and transmit a significant change in status assessment.

Whenever a resident experiences a significant change in status, regardless of whether there was also an error on the previous assessment, a significant change in status assessment must be completed by the end of the 14th calendar day following the determination that a significant change occurred.

Significant change in status assessments and significant correction of prior assessments are entirely new assessments of the resident, based upon a new assessment reference date (MDS Item A3a).

The Correction Policy Summary matrix, Exhibit 273, provides a quick reference to all the correction policy scenarios. This matrix provides a summary checklist of all the actions required for each scenario.

3) Parameters for Correcting (Modifying or Inactivating) MDS Information in the State Database.--

a) Types of Corrections That Should be Made.--Facilities should correct any errors necessary to insure that the information in the State MDS database accurately reflects the resident's identification, discharge or reentry status, overall clinical status, or the resident's Medicare, Medicaid or Social Security Number. It is not HCFA's intent that a record be corrected when the only errors are trivial (e.g., the lifetime occupation in MDS item A6 has been misspelled). States have the option to require more extensive correction. However, States may not impose requirements that interfere with the federal MDS requirements or system specifications. If there is uncertainty about the correction requirements in a particular State, the State RAI coordinator should be contacted for clarification.

b) Time Length Between Error Detection and Correction.--It is expected that a Correction Request Form will be completed within 14 days of error detection. If circumstances have precluded timely completion, corrections should be made as soon as possible. Documentation must be included in the resident's clinical record indicating the date(s) that error(s) were detected.

c) Time Length Between Acceptance and Correction.--A correction may be submitted for any accepted record, regardless of the age of the original record. For example, a record accepted 2 years ago can still be modified. However, certain limitations might apply for specific system applications. For example, a time has been placed on using corrections for making payment adjustments.

d) Correction of Non-Current Records.--A record may be corrected even if subsequent records have been accepted for the resident. For example, an admission assessment may be corrected after one or more subsequent quarterly assessments have been accepted.

e) Regarding Changing Dates on the MDS.--In most cases, a correction to an MDS assessment will not involve changing any of the dates in the record. The only time any date on an MDS record should be modified is when the facility can substantiate that the date itself was in error. The facility should not update the assessment completion dates (MDS Items R2b, VB2, and VB4) to the date the correction is being made. Even when an assessment is corrected, the completion dates should usually remain unchanged from the original completion times.

f) Number of Items Changed in a Modification Request.--There is no limit to the number of items that can be changed in one assessment or tracking form record with a single modification request.

g) Number of Modification Requests for a Record.--There is no practical limit to the number of sequential modifications that may be requested for a record (up to 99 sequential changes are allowed). If a record has been previously modified and additional errors are detected, then an additional correction should be submitted. Similarly, if a modification itself is in error, then a subsequent correction should be submitted.

h) Transition Rule With Implementation of Correction Policy.--For records accepted before implementation of correction policy, the facility may optionally make corrections, however correction of these records is not a federal requirement. It is not HCFA's intent that facilities review and correct all historic records submitted before implementation of correction policy. For MDS records accepted after implementation of correction policy, facilities should correct any errors that misrepresent the resident's identification, location, overall clinical status, or payment status.

7. Retention of Correction Request Forms and Substantiating Documentation.--

o There must be documentation in the resident's clinical record that clearly substantiates the accuracy of the corrected information, relative to the resident's actual status as of the event date of the erroneous record (MDS item A3a for an assessment, MDS Item R4 for a discharge, or MDS Item A4a for a reentry).

o Documentation must be included in the resident's clinical record indicating the date(s) that error(s) were detected.

o A hard copy of the completed MDS Correction Request Form, including the signatures of the facility staff attesting to the completion and accuracy of the corrected record, must be attached to the appropriate MDS form and retained in the active clinical record for 15 months from the date the correction request was completed, at Item AT7 on the MDS Correction Request Form.

o In the case of a modification, a facility must correct the original MDS form, using standard medical record procedure, clearly indicating and initialing all items that have been changed, the date of the change, and the corrected values. The modification request and attached corrected MDS form must be maintained in the resident's active clinical record for 15 months as noted above.

o When more than one modification is performed, a facility must document the sequence of corrections on the original MDS form. For each set of corrections, an MDS Correction Request Form must be attached to the corrected MDS form documenting the associated corrections. It is acceptable to have multiple MDS Correction Request Forms attached to a single MDS form, as long as that MDS form documents all corrections made. This documentation must be legible.

o When more than one modification is performed, a facility must document the sequence of corrections on the original MDS form. For each set of corrections, an MDS Correction Request Form must be attached to the corrected MDS form documenting the associated corrections. It is acceptable to have multiple MDS Correction Request Forms attached to a single MDS form, as long as that MDS form documents all corrections made. This documentation must be legible.

o In the case of an inactivation, a facility must simply attach the MDS Correction Request Form to the erroneous MDS form to be inactivated. The inactivation request and erroneous form should then be maintained in the resident's active clinical record for 15 months as noted above. Retention of information in a resident's clinical record is obviously not an option in the event that the resident did not actually exist (e.g., fabricated test record). In this case, the inactivated record must still be retained for 15 months, however it may be kept in a common file.

o For corrections to records that had not been previously accepted into the MDS database at the State, the electronic and paper records are corrected in the facility and use of the MDS Correction Request Form does not apply. Paper records should be corrected using standard medical records procedures. That is, the person responsible for the accuracy of the information enters the correct response, draws a single line through the previous response without obliterating it, and initials and dates the corrected entry.

D. Facility Requirements for Automating and Transmitting MDS Data, and Database Management.--

1. Process of Data Flow From Facility to State.--

a. Encode, Edit, and Lock the MDS Records.--Final completion of a comprehensive resident assessment (including RAPs and care plan decisions), is represented by the date at MDS Item VB4. Completion of any noncomprehensive assessment, or of a full assessment without RAPs, is represented by the date at MDS Item R2b.

After a facility completes a resident assessment, Discharge or Reentry Tracking form, the facility must encode and edit according to HCFA specifications. Each record must be transmitted to the State no later than 31 days after its final completion date. Refer to Exhibit 263, Submission Timeframe for MDS Records, encoding, editing and transmission. Also refer to Exhibit 274, Definition of Important Dates in the RAI Process, for a description of critical dates in the MDS process.

An MDS record (assessment or tracking form) is considered locked when accepted into the MDS database at the State. This locking policy does not extend the MDS editing period beyond 7 days. The 7 day editing period following assessment or tracking form completion plays an important role in the MDS process. The end of the 7 day time period is the point at which the care plan is established or updated based on information in a completed assessment. If the record is not submitted and accepted by the end of the 7 day editing period, then a formal, paper audit trail must be maintained in the facility for any subsequent changes, until the record is accepted by the State. Any corrections after the editing period must reflect resident status and condition as of the original Assessment Reference Date.

Discharge and Reentry Tracking Forms must be encoded and edited within 7 days of the *event*. The date of the event is represented by the date at MDS Item A4a for a Reentry, and the date at MDS Item R4 for a Discharge.

Each facility is ultimately responsible for submitting accurate data. Once assessments are performed, facility staff must validate that the information on the MDS accurately reflects the resident's condition and clinical record. Once the data are encoded, they must be both verified to assure that the information entered into the facility's computer system matches the information on the MDS form, and edited, to assure that the data conform to the Standard MDS Record Layout and HCFA's MDS edits posted as on HCFA's wed site: http://www.hcfa.gov/medicaid/mds20, under "MDS Software and Data Specifications" and then under the MDS Data Specifications, "Version 1.10 Files". Editing can be accomplished manually (that is visually), although HCFA strongly encourages use of software that has a programmed edit capability that uses HCFA's edit specifications.

b. Export MDS Records /MDS Export File.--MDS vendor software creates the export file by gathering one or more records to be transmitted, putting the data into HCFA standard format, and adding standard Header and Trailer records.

c. Communications Software (Netscape) and the MDS Submission File.--The export file is then electronically transmitted to the State MDS system via communications software (e.g., Netscape.) The export file, also known as a submission file, is electronically transmitted to the State database.

2. Initial Feedback and Final Validation Reports.--After the export *file* (batch of MDS records) is submitted to the standard MDS system at the State, the system examines the integrity and structure of the file. The entire file will be rejected if it has "fatal *file* errors". If there are no fatal

file errors, the file will be accepted and loaded into the State MDS database. An Initial Feedback Report is sent electronically from the State to the facility, indicating whether the file was accepted or rejected. If the file was rejected, the Initial Feedback Report includes an error statement indicating the reason(s) for rejection. Rejected files must be corrected and re-transmitted.

If the file is accepted, the standard MDS system at the State performs more extensive edits on each individual MDS *record* in the file, using HCFA's standard edit specifications, to determine whether there are errors. The system will reject individual records with "critical errors" (also referred to as fatal *record* errors), and accept records with no critical errors. A Final Validation Report is sent electronically from the State to the facility that includes error statements for individual records found to have errors, and record rejection statements (with associated error statements) for any records rejected. Rejected records must be corrected and re-transmitted within the original 31day submission timeframe, (see Correction Policy for MDS Records) in part IV of Appendix R. For more detailed information regarding the Validation and Editing Process, refer to §4146.

3. Timing and Frequency of Transmissions of MDS Data to the State.--A facility must transmit MDS data at least monthly to the States. "Monthly" means submitting a record no later than 31 days from its *final completion date* (as defined above). The final completion date counts as day 0 (zero) in the 31 day count.

Transmissions must be no more than 1 month apart. The time interval between the final completion date and transmission date could be between 0 days to 31 days.

It is recommended that transmission files (batches) include all MDS records completed since the last transmission, including rejected records that are being retransmitted.

4. Preservation of Data .--HCFA strongly recommends that facilities establish a back-up capability and routine that preserves both data and programs. Automatic back-up routines ensure that back-ups are performed consistently. Back-up routines should include validation. Facilities should periodically test their ability to restore their system from backups on a test system.

Facilities may wish to consider periodically backing up their entire hard drive, as well as their data. It may also be useful to periodically store a back-up off site, and update that back-up at specified intervals. Facilities may also wish to consider virus protection (such as virus checking software and policy regarding handling of diskettes brought in from the outside), as well as protecting data in the event of a power surge (such as the use of Uninterruptible Power Supply (UPS) systems).

5. System Access and Passwords.--It is recommended that facilities consider software that will allow the use of individual passwords that, for security reasons, can limit access to specified portions of the system. For example, for a facility considering software that will automate clinical records beyond the MDS, such as progress notes, nursing staff should be permitted to read and write nursing progress notes, and only read and not write therapy progress notes. There may also be areas of the system that only the facility system administrator should have access to, such as areas where passwords are assigned and disabled. Facilities might wish to consider that staff not responsible for system administration tasks have no access to those areas. Also, in order to provide an audit trail, it is important that an individual staff member's password links their name with their work. We advise that facility staff also be cautioned against "posting" passwords. Finally, it is recommended that facilities consider policy regarding disabling passwords in the event of staff termination.

6. Maintaining a Submission Log.--To provide an audit trail, facilities may wish to consider keeping data submission logs of submission file (batch) lists, Initial Feedback and Final Validation Reports, as well as actions taken on errors and rejected records or files.

E. Privacy, Confidentiality and Resident's Rights.--

1. Facility Release of Information.--MDS data are considered to be a part of the resident's clinical record, and as such, are protected from improper disclosure by facilities under the requirements of 42 CFR Part 483.10(e). Facilities must keep confidential all information contained in the resident's record and maintain safeguards against the unauthorized use of resident clinical information, regardless of storage method. Circumstances that may necessitate the release of information from the resident's clinical record are limited by regulation (42 CFR Part 483.10 (e) to circumstances required:

(1) By transfer to another health care institution;
(2) By law; or
(3) By the resident.

A facility may not release resident identifiable information to the public. Providers who are part of a chain may release data to their corporate office or parent company but not to other providers within their chain. The parent company is required to "act" in the same manner as the facility and permitted to use data only to the extent the facility is permitted to do so.

The release of data by facilities to other agents who are under contract and have a need to know the MDS information (including but not limited to physicians, physical therapists, occupational therapists, or other specialists) in order to develop plans of care and/or agents who are under contract to handle the data for administrative reasons, such as for transmission to the State repository or to develop quality indicator reports, are required to "act" in the same manner as the facility and permitted to use data only to the extent the facility is permitted to do so.

2. Residents' Rights.--

a. Notification of Residents.--Nursing Homes must inform each resident about the electronic transmission of the MDS to the State and HCFA. This is done because the data will be part of the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517, and therefore are ultimately subject to the Federal Privacy Act of 1974.

To properly inform the residents of their rights under the Privacy Act, the provider must furnish each resident with information required by the Privacy Act. Under the requirements of the Privacy Act, notices must contain the following information: (1) the authority for collection of information, including social security number; (2) the principal purposes for which the information is intended to be used; (3) the routine uses for which the information may be disclosed, and (4) the effect on the individual of not providing information. The Exhibit provides one example of the required information for a Privacy Act Notification for the Long Term Care Minimum Data Set System of Records. This required information includes:

b. Authority for Collection of Information, Including Social Security Number, and Whether Disclosure is Mandatory or Voluntary.--**Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.**

Medicare and Medicaid participating long term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by HCFA to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the HCFA contractor in the State government, which in turn transmits the information to HCFA.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long Term Care System of Records.

c. Principal Purposes for Which Information is Intended to Be Used.--The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing homes that participate in Medicare or Medicaid. Submission of MDS information is also necessary for the nursing homes to receive reimbursement for Medicare services.

d. Routine Uses.--The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: (1) a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of that individual; (2) the Federal Bureau of Census; (3) the Federal Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health; (5) contractors working for HCFA to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

e. Effect on Individual of Not Providing Information.--The information contained in the Long Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare/Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

This information must be provided in writing to each current and future resident (or his/her representative) under the requirements of 42 CFR Part 483.10 (b) and the Federal Privacy Act of 1974. For residents who have legal representatives, providers can provide a copy of the notice in person or by mail. For new under the requirements of 42 CFR Part 483.10 (b) and the Federal Privacy Act of 1974. For residents who have legal representatives, providers can provide a copy of the notice in person or by mail. For new admissions, a copy of the Privacy Act Notification can be a part of the admission packet that is given to and reviewed with the resident or representative at the time of admission.

Providers may or may not elect to have residents or their representatives sign a copy of the notification as a matter of record that the notice was provided. The signature of a resident or representative merely indicates that notification was provided.